UHCR 2

Office of the President
October 25, 2005

Members, Board of Trustees:

UNIVERSITY HOSPITAL BYLAWS OF THE MEDICAL STAFF

Recommendation: that the Board of Trustees approve the newly revised Bylaws of the Medical Staff which are attached hereto.

Background: The Governing Regulations establishing the University Hospital Committee allow the Committee to enact its own operating rules and to function as the governing body for the University Hospital in accordance with the requirements of the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO). As part of its responsibilities as a governing body, the University Hospital Committee approves, subject to the university Board of Trustee's ratification, the University Hospital Bylaws of the Medical Staff. The University Hospital Committee approved these revised Bylaws of the Medical Staff at its September 20, 2005 meeting. These revised bylaws set forth organizational changes that have been made to the medical staff and changes suggested by recent guidance from JCAHO concerning medical staff governance.

Action taken: ☑ Approved as amended ❑ Disapproved ❑Other _____

BYLAWS
OF THE MEDICAL STAFF

UNIVERSITY HOSPITAL
CHANDLER MEDICAL CENTER,
UNIVERSITY OF KENTUCKY

PREAMBLE

The University Hospital of the Chandler Medical Center is a part of the University of Kentucky, a publicly supported institution of post-secondary education established and maintained pursuant to Chapter 164 of the *Kentucky Revised Statutes*. A primary function the medical staff of the University Hospital is to oversee the quality and safety of care, treatment and delivery of health care services to the patients in the University Hospital. In order to provide a framework within which the medical staff shall function, these *Bylaws* and *Rules and Regulations* shall govern those physicians and dentists and related health professionals who practice or seek to practice at the University Hospital.

Subject to the final authority and approval by the University Hospital Committee and the Board of Trustees of the University of Kentucky, the medical staff shall exercise such self-governance and power reasonably necessary to discharge its responsibilities under these *Bylaws* and *Rules and Regulations* (which shall not be considered to be a contract).

DEFINITIONS

1. *Medical staff* means a single, organized self-governing body, subject to the final authority and approval by the University Hospital Committee and the Board of Trustees, that is comprised of all licensed medical physicians and dentists who are privileged to attend patients at the University Hospital.

2 . *Health-related professions staff* (*or independent licensed practitioner*) means all health-related professionals who are privileged to attend patients at the Hospital.

3. *Practitioner* means a medical or health care professional who has a license to practice his or her profession in Kentucky and who otherwise is eligible for appointment to the medical staff.

4. *Medical staff year* means that period of time commencing on the first day of July of any calendar year and ending on the thirtieth day of June of the following calendar year.

5. *Hospital* means the University Hospital of Chandler Medical Center, University of Kentucky.

6. *Associate Vice President for Medical Center Operations* means the individual who oversees the overall management of the Hospital.

7. *University Hospital Committee* means that body appointed by the Board of Trustees, whose members conduct and manage the governance of University Hospital, with powers as defined in the *Bylaws: University Hospital of the Chandler Medical Center*. For purposes of accreditation as it relates to these *Bylaws*, the University Hospital Committee is considered the "governing body."

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8. *Chair of the University Hospital Committee* means the chair of the University Hospital Committee of the Chandler Medical Center.

9 *Board of Trustees* means the Board of Trustees of the University of Kentucky.

10. Executive Vice President for Health Affairs means the Executive Vice President for Health Affairs for the University of Kentucky who is the primary representative of the University of Kentucky Chandler Medical Center to the University Hospital Committee.

11. *Dean of the College of Medicine* means that individual responsible for management of the Medical Center clinical professional program and for coordination, development, and review of clinical programs in University clinical facilities and affiliated locations.

12. *President* means the president of the University of Kentucky.

13. *Credentials Committee* means the committee of the Medical Staff to which the University Hospital Committee has delegated the authority to grant initial appointment and reappointment, as well as the authority to grant initial, renewal or modification of clinical privileges, subject to review, ratification and finalization by the University Hospital Committee acting as governing body.

14. *Medical Staff Executive Committee* means that body composed as described in Article XIV, The Medical Staff Executive Committee shall be the executive committee of the medical staff.

15. *President of the Medical Staff* means the elected individual bearing that title within the Hospital who serves as the chief administrative officer and representative of the medical staff with oversight responsibility relating to the quality and safety of patient care, the proper functioning of the medical staff, compliance with these *Bylaws* and *Rules and Regulations* by the medical staff, and coordination of the work of the clinical departments.

16. *Designee* means the individual(s) who, in the absence, or at the request, of the University Hospital Committee, Medical Staff Executive Committee, President of the Medical Staff, Chief Medical Officer, or Director of Medical Affairs, performs certain authorized and delegated duties described in these *Bylaws*.

17. Chief Medical Officer means Chief Medical Officer for the University of Kentucky.

18. Director of Medical Affairs(DMA) means the individual appointed by the Chief Medical Officer who oversees the creation and operation of processes relevant to the medical staff including, but not limited to, credentialing and related processes.

ARTICLE I

PURPOSE

SECTION 1. The purpose of the medical staff, as an organized component of the Hospital, is to:

A. organize the activities of practitioners in the Hospital in order that they may carry out, in conformity with these *Bylaws*, the functions delegated to them by the University Hospital Committee;

B. provide that all patients, regardless of race, color, religion, national origin, gender, age or disability, receive continuous, quality medical care from practitioners appointed to the medical staff;

C. maintain and enhance the professional performance of all members of the medical staff through ongoing review, evaluation, and improvement of clinical performance;

D. provide an appropriate educational setting to maintain scientific standards that will lead to a continuous advancement in professional knowledge, skill, and training;

E. initiate and maintain rules, regulations, and policies for internal governance of the medical staff;

F. provide a means for issues concerning the medical staff directly discussed by the medical staff with the University Hospital Committee and with Hospital Administration, with the understanding that the medical staff is subject to the ultimate authority of the University Hospital Committee and that cooperative efforts among the medical staff, administration, and University Hospital Committee are necessary to fulfill the purposes and missions of the Hospital; and

G. serve as the primary means for the medical staff's accountability to the University Hospital Committee for the quality and appropriateness of the professional performance and ethical conduct of practitioners.

SECTION 2. The purpose of these *Bylaws* is to:

A. establish a framework within which the fundamental objective of the Hospital to provide comprehensive medical services, including diagnostic and curative medical care, preventive medical care, care and rehabilitation of the chronically ill and disabled, dental care, and facilities for education and research for those engaged in activities related to comprehensive medical services may be effectuated through orderly governance and through the performance of credentialing;

B. promote communication and interaction between departments, services, and functions throughout the Hospital in order to improve operations and clinical outcomes;

C. facilitate effective cooperation with other affiliated and non-affiliated hospitals and other community health agencies serving the central and eastern Kentucky area;

D. facilitate effective affiliation with other hospitals and educational institutions to assist in the education of physicians, dentists, nurses, pharmacists, and health-related professionals;

E. facilitate the formulation of long-range and short-range health planning goals;

F. provide a method of continuous self-evaluation of the medical services through the delineation of staff privileges and review of clinical activities in order to improve performance and clinical outcomes;

G. develop and maintain high standards in medical education programs and provide for continued medical education of practitioners; and

H. provide a means whereby issues concerning the medical staff and the Hospital may be discussed and resolved.

ARTICLE II

MEDICAL STAFF MEMBERSHIP

SECTION 1. Medical Staff Membership

A. No practitioner shall admit patients to the Hospital unless that practitioner is a member of the medical staff and has been granted clinical privileges in accordance with the procedures set forth in these *Bylaws*. Appointment to the medical staff shall confer only such clinical privileges as have been granted in accordance with these *Bylaws*.

B. Membership on the medical staff of the Hospital is a privilege extended only to those practitioners who continuously meet the qualifications, standards, and requirements set forth herein.

SECTION 2. Eligibility for Membership

Physicians and dentists licensed to practice in Kentucky and who are currently, or have faculty application in process and before final action taken by the University Board of Trustees. In the event the applicant is not appointed to the faculty, his/her Medical Staff appointment and clinical privileges automatically will terminate, without a hearing or appeal.

SECTION 3. General Qualifications

Only practitioners who:

A. document or provide evidence of (1) current licensure ("regular license," "limited license-institution practice," or "teacher-limited license" as described by *KRS, Section 311.550, Section 313.040, or Section 313.035*) in good standing and without restriction imposed by the Board of Medical Licensure or the Board of Dentistry; (2) adequate experience, education, and training, and, for physicians, possessing currently valid American Board of Medical Specialties specialty/subspecialty qualification/certification, or demonstrating equivalent training/experience acceptable to the Credentials Committee; (3) current professional competence; (4) good clinical and professional judgment and skills; and (5) adequate physical and mental health status, with or without reasonable accommodations, relating to the exercise of the clinical privileges requested; and

B. demonstrate willingness and ability to work cooperatively with other practitioners in a professional manner; and

C. demonstrate that they are professionally currently competent and that patients treated by them can reasonably expect continuous, quality medical care shall be deemed to possess the basic qualifications for membership in the medical staff, except for the honorary staff category, in which case these criteria shall only apply as deemed individually applicable by the Hospital.

SECTION 4. Basic Responsibilities of Medical Staff Membership

Except for the honorary staff, the ongoing responsibilities of each member of the medical staff shall include, without limitation:

A. Continuously providing patients in a reasonably efficient manner with quality care that meets generally recognized professional standards.

B. Abiding by the *Medical Staff Bylaws, Rules and Regulations*, medical staff and Hospital policies, *Behavioral Standards in Patient Care*, and the Medical Center's Corporate Compliance Program.

Maintain confidentiality and the proper use and disclosure of Protected Health Information, as provided by HIPAA's Privacy Rule.

C. Completing such reasonable responsibilities, assignments, and rotations required by virtue of medical staff membership, including committee assignments, proctoring of practitioners, attendance requirements, and accreditation requirements.

D. Supervising residents (post-graduate medical and dental trainees) as appropriate to their level of training, according to Hospital policy 09-33, Supervision of House Staff.

E. Participating on, with, or in Hospital or multidisciplinary committees, teams, or programs dealing with the overall medical environment at the Hospital including, without limitation, such functions as medical records, quality improvement, utilization review, practice guidelines, blood usage blood component review, nursing services, drug usage and formularies, infection control, radiation safety, risk management, operative and invasive procedure review, safety, and patient care policies.

F. Preparing and completing in timely fashion all medical records for the patients to whom the member provides care in the Hospital.

G. Aiding and participating in approved educational programs for medical students, interns, resident physicians, resident dentists, physicians and dentists, podiatrists, clinical psychologists, nurses, and other personnel.

H. Making timely and appropriate arrangements for coverage of patients.

I. Desisting from improper inducements for patient referral or other unethical behavior.

J. Maintaining current professional competence through appropriate continuing education programs.

K. Participating in emergency service coverage or consultation panels.

L. Informing the Office of Chief Medical Officer (DMA) or the President of the Medical Staff or designee, in a timely manner, of any changes made or formal action initiated that could result in a change of license, DEA registration, participation in any program or plan for the reimbursement of services, professional liability insurance coverage, membership, employment status or clinical privileges at other health care institutions or affiliations, and the status or initiation of malpractice claims.

M. Performing a sufficient number of procedures, managing a sufficient number of cases, and having sufficient patient care contact within the practitioner's practice to assess the practitioner's current clinical competence for any clinical privileges, whether being requested or already granted.

N. Participating in the Hospital's risk management program, quality assurance program, and peer review activities.

O. Seeking consultation, in accordance with generally accepted standards of patient care or when requested by the Office of Chief Medical Officer (DMA) or the President of the Medical Staff.

P. Attending physician / dentist or his/her designee must inform the patient of outcomes of care, including unanticipated outcomes.

Q. Discharging such other medical staff obligations as may be lawfully established from time to time by the medical staff, the Medical Staff Executive Committee, or the University Hospital Committee.

SECTION 5. Conditions and Periods of Appointment

Application for membership to the medical staff shall constitute the staff member's agreement to abide by these *Bylaws* and *Rules and Regulations*. In addition, membership shall require the practitioner to:

A. abide by the Principles of Medical Ethics of the American Medical Association, or the Code of Ethics of the American Dental Association, or Code of Ethics of applicable Allied Health Professions, as applicable;

B. maintain and uphold the *Behavioral Standards in Patient Care* adopted for University of Kentucky Chandler Medical Center, and

C. consent to alcohol and drug testing or psychiatric or medical evaluation when requested by the practitioner's clinical chief or Office of Chief Medical Officer (DMA) or the President of the Medical Staff; and

D. participate in communicable disease prevention by having:

1. Mantoux or similar tuberculin skin test annually (twice annually if employed in a high-risk area), or annual health questionnaire, and when deemed necessary, chest X-ray.

2. two MMR vaccines for all individuals born after 1956 who cannot provide evidence of previous vaccination, physician-diagnosed measles disease, or laboratory evidence of measles immunity.

3. hepatitis B immunization for individuals at risk unless previously immunized, diagnosed as immune by laboratory testing, or waived.

4. other immunizations as required by Hospital policy or state or federal law.

E. immediately inform the Office of Chief Medical Officer (DMA) or the President of the Medical Staff and risk manager of any actions or investigations that have resulted in, or could result in, the limitation, restriction, reduction, suspension, or revocation of any professional license, membership, clinical privileges, or subject to any investigation or action that could lead to being declared an "Ineligible Person", i.e. one who is debarred from participating in Medicare or any other federal health care plan.

SECTION 6. Provisional Status

Upon the recommendation by the Medical Staff Executive Committee, and after approval of an applicant's application by the University Hospital Committee (which shall not be bound by the Medical Staff Executive Committee's recommendation), an applicant shall be given a provisional appointment for a period of six (6) months or remainder of the first medical staff year, whichever is greater. Provisional status may be extended by the Medical Staff Executive Committee for up to two (2) additional terms of six (6) months for good cause. Provisional staff shall have all the privileges and duties of full staff members in their category except that they shall not be eligible to hold office or vote unless permitted to do so by the University Hospital Committee. At the end of the provisional period and on recommendation of the applicant's chief of service, which may be made by verbal report to the Medical Staff Executive Committee, full staff status will be given for a period not to exceed the end of the then current medical staff year. Reappointments shall be for a period of two (2) medical staff years.

Unless waived by the Medical Staff Executive Committee for good cause, each provisional member of the medical staff shall undergo a period of observation by designated monitors or proctors. The observation shall be to evaluate the member's (1) proficiency in the exercise of clinical privileges initially granted and (2) over-all eligibility for continued medical staff membership and advancement within medical staff categories. Observation of provisional members shall follow whatever frequency and format each department or division deems appropriate in order to evaluate adequately the provisional member including, but not limited to, concurrent or retrospective chart review, mandatory consultation, and/or direct observation. The results of the observation shall be communicated by the department chair or President of the Medical Staff to the Medical Staff Executive Committee.

ARTICLE III

CATEGORIES OF THE MEDICAL STAFF

SECTION 1. Medical Staff Categories

The single organized medical staff shall be divided into categories denominated honorary, active, clinical fellow, associate, and voluntary.

SECTION 2. Honorary Category

The honorary category shall be comprised of physicians and dentists who were previously members of the active staff who are no longer actively practicing in the Hospital. These may be physicians and dentists who have retired from active hospital practice or who are of outstanding reputation, not necessarily residing in the community. Honorary staff members shall not be eligible to admit patients, vote, hold office, or serve on standing medical staff committees.

SECTION 3. Active Category

The active category shall be comprised of physicians and dentists who are full-time faculty members of the University of Kentucky College of Medicine or Dentistry; who hold clinical unrestricted medical or professional licenses to practice their profession in the Commonwealth of Kentucky; and who have been endorsed by their

respective departmental, divisional, and sectional chair as being active in the teaching program of the University. Only members of the active staff shall be eligible to vote at any meetings of the medical staff. Privileges shall be delineated upon appointment and with each reappointment. Members of the active staff shall be required to attend meetings of the medical staff and to serve on standing or *ad hoc* medical staff committees.

SECTION 4. Clinical Fellow Category

The clinical fellow category shall be comprised of physicians and dentists who are employed full-time by the University of Kentucky; who hold clinical unrestricted Kentucky licenses to practice their profession in the Commonwealth of Kentucky; who have completed all residency requirements for specialty boards and where applicable subspecialty boards; and who have been endorsed by their respective departmental, divisional, and sectional chair as being engaged in specifically defined post-residency programs of research development, investigation, training, and/or clinical fellow patient care programs. Privileges shall be delineated on appointment and with each reappointment. Members of the clinical fellow category may attend medical staff meetings without vote, serve on standing medical staff committees and, as a member of the University Hospital, may admit and manage patients in the Hospital and clinics.

SECTION 5. Associate Category

The associate category shall be comprised of physicians and dentists who are part-time faculty of the University of Kentucky College of Medicine or Dentistry; who hold clinical unrestricted Kentucky licenses to practice their profession in the Commonwealth of Kentucky; and who have been endorsed by their respective departmental, divisional, and sectional chair as contributing to the programs of the University. Privileges shall be delineated upon appointment and with each reappointment. In general, admission privileges shall be limited to periods of active involvement in teaching. Members of the associate staff may not hold office and do not have voting privileges at meetings of the medical staff, but they may attend medical staff meetings and serve on standing or *ad hoc* medical staff committees.

SECTION 6. Voluntary Category

The voluntary category of staff shall be comprised of physicians and dentists who are volunteer faculty of the University of Kentucky College of Medicine or Dentistry; who hold clinical unrestricted Kentucky licenses to practice their profession in the Commonwealth of Kentucky; and who have been endorsed by their respective departmental, divisional, and sectional chair as contributing to the programs of the University. Privileges shall be delineated upon appointment and with each reappointment. Members of the volunteer faculty at the time they request privileges must provide the Hospital with recommendation of three licensed physicians or dentists who can attest to their professional qualification for the privileges they seek, and provide evidence of satisfactory staff function from the hospitals where they concurrently hold, or in the recent past have held, privileges. They must with each application or reapplication provide evidence of malpractice insurance sufficient to cover the reasonable anticipated risks of their specialty as defined by the University of Kentucky Malpractice Committee. Members of the volunteer staff may not hold office and do not have voting privileges at meetings of the medical staff, but they may attend medical staff meetings and serve on standing medical staff committees.

ARTICLE IV

HEALTH-RELATED PROFESSIONS STAFF
[Independent Licensed Practitioners]

SECTION 1. Membership and Identification

The health-related professions staff shall be comprised of licensed practitioners including, without limitation, those who are faculty members of the University of Kentucky and/or employees of the University of Kentucky and selected volunteers, who are appointed by the University Hospital Committee. Members of the health-related professions staff shall be identified as health-related professions staff of a particular clinical department or service. Though members of the health-related professions staff shall not be considered members of the medical staff they nevertheless shall be bound by these *Bylaws* and *Rules and Regulations*, except that they shall not be entitled to the procedures set forth in Article XI.

SECTION 2. Privileges

Members of the health-related professions staff shall have privileges delineated in accordance with the scope of their licensure, as permitted by statute and as granted upon appointment. Privileges for individuals involved with the management of patients will be under the supervision of an active medical staff member and will be strictly limited to the performance of specialized services within the field of the member's competence.

The privileges will be specifically designated by individual by the University Hospital Committee and will be noted in the individual's credentials file.

SECTION 3. Application Process

All applications for appointment to the health-related professions staff shall be submitted on a form developed by the Office of Chief Medical Officer (DMA) and approved by the Medical Staff Executive Committee and University Hospital Committee. Such forms are to be completed and signed by all applicants who, as a condition to applying, shall agree to be bound by these *Bylaws, Rules* and *Regulations*, and policies of the medical staff and Hospital. The procedures, inquiries, and commitments set forth in Article IV of these *Bylaws* for membership on the medical staff shall likewise apply to membership on the health-related professions staff, and submission of a completed application for membership on the health-related professions staff shall constitute acknowledgment by the applicant that the medical staff procedures, inquiries, and commitments are applicable.

SECTION 4. Condition and Periods of Appointment

A. The same conditions and periods of appointment set forth in these *Bylaws* for members of the medical staff shall likewise apply to applications and members of the health-related professions staff.

B. Appointment to the health-related professions staff shall confer on the appointee only such clinical privileges as have been set forth in the appointment.

C. Appointment shall be for 12 months.

ARTICLE V

PROCEDURE FOR APPOINTMENT AND REAPPOINTMENT

SECTION 1. General

No practitioner (including practitioners engaged by the Hospital by contract and/or practitioners holding medical staff offices or administratively responsible positions) shall exercise clinical privileges in the Hospital unless and until the practitioner applies for and receives appointment to the medical staff or is granted temporary privileges as set forth in these Bylaws. By applying to the medical staff for appointment or reappointment (or, in the case of members of the honorary staff, by accepting an appointment to that category), the applicant acknowledges responsibility to review these *Bylaws*, and agrees that throughout any period of membership the applicant will comply with the responsibilities of medical staff membership and will be bound by the *Bylaws, Rules and Regulations*, and policies of the medical staff as they exist and as they may be modified from time to time.

SECTION 2. Nondiscrimination

Medical staff membership or particular clinical privileges shall not be determined or denied on the basis of an applicant's gender, race, age, religion, color, national origin, or disability.

SECTION 3. Application Process

Persons who request an application form shall be referred to the Web site publishing these *Bylaws, Rules and Regulations,* and summaries of other applicable policies related to clinical practice in the Hospital, including the *Behavioral Standards in Patient Care* adopted by the University of Kentucky Chandler Medical Center.

A. All applications for appointment to the medical staff shall be submitted on a form developed by the Office of Chief Medical Officer (DMA) and approved by the Medical Staff Executive Committee and the University Hospital Committee. Such forms are to be completed by all applicants, signed by the applicant, and shall contain the applicant's specific acknowledgement of the applicant's obligation to provide continuous care and supervision of their patients; to accept, attend and complete required committee assignments; and to accept consultation assignments. In addition, the applicant shall specifically acknowledge that any misrepresentation or failure to fully disclose requested information shall be sufficient to result in the immediate revocation of the applicant's appointment or denial of their application for appointment.

B. Burden of Producing Information

In connection with all applications for appointment, reappointment, advancement, modification of clinical privileges, or transfer, the applicant or member shall have the burden of timely producing complete and

accurate information for an adequate evaluation of the applicant's qualifications and suitability for the clinical privileges and the medical staff category requested, of resolving any reasonable doubts about these matters, and of satisfying reasonable requests for information including requests for interviews. The applicant's failure to sustain this burden in a timely fashion shall be grounds for denial of the application, which shall be considered as voluntarily withdrawn, without any procedural rights under Article XI. This burden may include submission to a medical or psychiatric examination at the applicant's expense, if deemed appropriate for the clinical privileges requested, and the Office of Chief Medical Officer (DMA) or the President of the Medical Staff or designee will select the examining physician.

C. The applicant shall supply detailed information as to the following:

1. The applicant's qualifications, including, but not limited to, professional training and clinical experience, judgment, current licensure in good standing and without restriction imposed by the Board of Medical Licensure, professional liability insurance, current DEA registration (if applicable), and continuing medical education information related to the clinical privileges requested.

2. A minimum of one peer reference familiar with the applicant's professional competence (preferably a reference on professional competence should be from someone of the same specialty or training) and character during the prior five (5) years.

3. Requests for membership categories, departments and divisions, and clinical privileges.

4. Previous, and currently pending, professional disciplinary actions, or licensure limitations, irrespective of reinstatement.

5. Voluntary or involuntary termination of medical staff membership; voluntary or involuntary limitation, reduction, withdrawal, or loss of clinical privileges at another hospital, health care entity, or managed care plan, irrespective of reinstatement, or withdrawal of an application for medical staff membership or clinical privileges prior to final action by the Hospital; together with a written explanation for such termination or withdrawal, which includes whatever relevant third-party information is available to the applicant.

6. Medical staff membership or clinical privileges at any health care facility, program, or managed care plan that are currently the subject of an investigation or corrective or disciplinary action and the reasons for same.

7. Any pending application for medical staff membership or clinical privileges at another health care facility, program, or managed care plan.

8. Physical and mental health status as they relate to the applicant's ability, with or without reasonable accommodation, to exercise the clinical privileges requested.

9. Final judgments or settlements, together with pending actions, against the applicant in professional liability actions and current professional liability insurance in such amounts and types as are required by the Hospital.

10. Reports to the National Practitioner Data Bank involving the applicant.

11. Applicant's PRO history, if applicable.

12. Any criminal convictions, involving any felony and any misdemeanor, provided the misdemeanor involved professional activity or a crime of moral turpitude.

13. Sequential history of medical or dental career, accounting for every year since graduation from professional school, which must include any leave of absence.

14. Whether the applicant's license to practice any profession in any jurisdiction has ever been voluntarily or involuntarily relinquished, suspended, or terminated, and whether there have been previously successful or there are currently pending challenges to any licensure or registration (state or federal, including DEA);

15. Whether the applicant's membership in local, state, or national medical or dental or other societies has ever been voluntarily or involuntarily revoked, suspended, or not renewed; and

16. Whatever additional reasonable information the Hospital or the medical staff deems relevant.

D. By applying for appointment to the medical staff, each applicant:

1. Signifies his/her willingness to be bound by the *Bylaws* and *Rules and Regulations.*

2. Signifies his/her willingness to appear for interviews, if requested, regarding the application; authorizes consultation by the department chair (chief of clinical service), the Credentials Committee, the Dean of the College of Medicine, the Office of Chief Medical Officer (DMA), President of the Medical Staff, the Medical Staff Executive Committee, the Associate Vice President for Medical Center Operations, Executive Vice President for Health Affairs, members of the University Hospital Committee, members of the Board of Trustees, peers and other members of medical staffs of other hospitals and ambulatory care programs with which the applicant has been associated, and with others who may have information bearing on the applicant's current competence, physical and mental health as it relates to the exercise of clinical privileges, character, and ethical qualifications.

3. Consents to the inspection, by any of the persons holding the above described offices, of all records and documents bearing upon the applicant's qualifications for clinical privileges and staff membership.

4. Agrees to immediately inform in writing the Office of Chief Medical Officer (DMA), and Hospital Risk Management of any change, voluntary or involuntary, of Hospital staff membership or clinical privileges, of licenses to practice medicine or dentistry, of membership in local, state, or national dental or medical societies, and/or of any involvement in professional liability action while a member of the University of Kentucky Hospital staff.

5. Releases from any liability all representatives of the University of Kentucky and its medical staff for their acts performed without actual malice in connection with evaluating the applicant and the applicant's credentials, and releases from any liability all individuals and organizations who provide information to the University of Kentucky or its medical staff without actual malice concerning the applicant's competence, ethics, character, and other qualifications for staff appointment and clinical privileges, including otherwise privileged or confidential information.

E. Upon completion of the application form, the applicant shall submit the signed application to the department chair or, in the case of health related professionals, to the appropriate department chair (chief of clinical service).

F. The department chair (chief of clinical service), with assistance of the medical staff coordinator, shall, with respect to each application form, verify from primary sources (when possible) the accuracy of the information supplied by the applicant and make inquiry to the National Practitioner Data Bank. In addition, the department chair (chief of clinical service) for each application and reapplication, shall prepare a written recommendation concerning the applicant that shall include an evaluation of the applicant's abilities to carry out staff responsibilities and a specific delineation of proposed privileges. The department chair's (chief of clinical service) recommendation shall become a part of the application.

   No action will be taken on a request for privileges until it is verified that the practitioner possesses an appropriate, current, and unrestricted medical or professional license; and that the practitioner has appropriate education, training, experience, current competence, judgment, and clinical skills to perform the clinical privileges requested.

G. The department chair (chief of clinical service) shall forward the application to the Office of Chief Medical Officer (DMA), who shall submit it to the Credentials Committee. The Credentials Committee, or an appropriate sub-committee thereof, shall obtain or inspect any and all records, letters of recommendation, performance improvement data, or other materials deemed pertinent. The Credentials Committee, with input and advice from its appropriate subcommittees, shall summarize its findings in the form of a recommendation including a delineation of clinical privileges, which shall become a part of the application.

H. The Credentials Committee, with input and assistance from the appropriate subcommittee, shall forward the application to the Office of Chief Medical Officer (DMA), who shall obtain or inspect any and all records, letters of recommendation, performance improvement data, or other materials deemed pertinent. The Office of Chief Medical Officer (DMA) shall summarize the findings in the form of a recommendation including a delineation of clinical privilege that shall become a part of the application, at which time the application shall be deemed verified and complete.

SECTION 4. Appointment Process

A. The Office of Chief Medical Officer (DMA) shall forward the completed application to the Medical Staff Executive Committee.

B. The Medical Staff Executive Committee shall review the completed application and prepare its written recommendation to become a part of the application. All recommendations to appoint must also

specifically recommend the clinical privileges to be granted, which may be qualified by probationary conditions relating to such clinical privileges.

C. The Medical Staff Executive Committee shall forward its recommendation through the Associate Vice President for Medical Center Operations to the Credentials Committee to which the University Hospital Committee has authorized to act on its behalf regarding credentialing decisions.

D. At its next regular meeting, following receipt of the application from the Associate Vice President for Medical Center Operations, the Credentials Committee shall act upon the application.

Once the Credentials Committee, acting on behalf of the University Hospital Committee, approves, modifies, or disapproves the application as submitted by the Associate Vice President for Medical Center Operations, including the recommended delineation of clinical privileges, it shall return the application to the Office of Chief Medical Officer (DMA), who shall notify the applicant in writing.

E. Upon receipt of the action of the Credentials Committee acting on behalf of the University Hospital Committee, on any application, the Office of Chief Medical Officer (DMA) shall send written notice to the Associate Vice President for Medical Center Operations, the Medical Staff Executive Committee, and the chair of the department concerned (chief of clinical service).

F. All actions of the Credentials Committee ,including the delineation of clinical privileges, shall be effective when taken, subject to review, ratification and finalization by the University Hospital Committee at its next regularly scheduled meeting.

G. Reapplication After Adverse Appointment Decision

An applicant who has received a final adverse decision regarding appointment and/or request for clinical privileges shall not be eligible to reapply to the medical staff for a period of one year from the date of the final decision. Any reapplication shall be processed as an initial application, and the applicant shall submit such additional information as may be required to demonstrate that the basis for the earlier adverse action no longer exists.

H. Timely Processing of Applications

Applications for medical staff appointment shall be considered in a timely manner by all persons and committees required by these *Bylaws* to act thereon. While special or unusual circumstances may constitute good cause and warrant exceptions, the following time periods provide a guideline for routine processing of applications: Final action shall be taken within 180 days from the date the application is deemed complete, unless *bona fide* questions exist regarding the applicant's education, qualification, current competency, or ability to exercise privileges and responsibilities under these *Bylaws*, in which case additional time up to days may be taken to act on the application.

I. Request that Application be Held in Abeyance

At any time in the application process prior to a recommendation by the Medical Staff Executive Committee to the University Hospital Committee for final action, an applicant may request that their application be held in abeyance for a period up to, but no greater than, 180 days, after which time the application shall lapse and expire with no right to the procedures set forth in Article X, and the applicant shall be required to submit a new application. The burden shall be on the application to update immediately any information.

J. Lapse of Application

If a medical staff member requesting a modification of clinical privileges or department or division assignment fails to timely furnish the information necessary to evaluate the request, the application shall automatically lapse, and the applicant shall not have procedural rights under Article X.

SECTION 5. Reappointment Process and Request for Modification of Staff Category or Clinical Privileges.

A. All applications for reappointment shall be submitted to the Medical Staff Office by the deadline established by the Medical Staff Office each year in which the reappointment is sought, at a minimum of every two (2) years, on a form developed by the Office of Chief Medical Officer (DMA) and approved by the Medical Staff Executive Committee and University Hospital Committee

B. Failure by a practitioner, without good cause, as determined in good faith by the Medical Staff Executive Committee, to timely file a completed application for reappointment by the reapplication due date shall result in the automatic expiration of the member's medical staff appointment and admitting privileges at the end of the current medical staff appointment, unless otherwise extended by the Office of Chief Medical Officer (DMA). The member shall be immediately notified by certified mail. In the event

membership automatically expires for the reasons set forth herein, the procedural procedures set forth in Article X shall not apply.

C. The reappointment form shall be supplemental to the original application for appointment or the most recent application for reappointment, and the applicant shall supply any information about the applicant that is additional to that furnished on the original application form or that is furnished on their most recent reappointment application. All application for reappointment forms shall contain the acknowledgments, authorizations, and releases set forth in Article V, Section 3. Any request for a change in clinical privileges shall be included by the applicant on the reappointment form.

D. In addition, documentation of current Kentucky license, current federal narcotics registration, information regarding continuing education activities in which the applicant has participated since the last application (on request), and one peer letter attesting to the applicant's ability to perform the privileges requested shall accompany the reappointment application.

E. A medical staff member who seeks a change in medical staff status or modification of clinical privileges may submit such a request at any time upon a form developed by the Office of Chief Medical Officer (DMA), and properly completed, except that such application may not be filed within six (6) months of the time a similar request has been denied. The Medical Staff Executive Committee, through the Medical Staff Office and chiefs of service (department chairs), will verify any training or instruction involved and if the request is approved by the Committee or Credentials Committee authorized by the University Hospital Committee to act on its behalf, provide for a provisional or proctoring period and then evaluate the clinical results of such period.

F. Upon completion of the reappointment application, the applicant shall submit it to the applicant's department chair, or in the case of health-related professionals, the appropriate chief of clinical service. The department chair (chief of clinical service) shall, with respect to each application form, verify in writing on the form the accuracy of the information supplied by the applicant. The department chair (chief of clinical service) shall review the applicant's professional performance in discussion with fellow faculty; review of divisional and departmental quality of care activities. In addition, the department chair (chief of clinical service), from the information provided, obtained, and reviewed, shall prepare a written recommendation concerning the applicant, which shall include an evaluation of the applicant's abilities to carry out staff responsibilities and a specific delineation of proposed privileges. The department chair's (chief's of clinical service) recommendation shall become a part of the application, at which time application shall be deemed verified and complete.

G. The department chair (chief of clinical service) shall forward the application to the Office of Chief Medical Officer (DMA), who shall submit it to the Credentials Committee. The Credentials Committee, or an appropriate sub-committee thereof, shall obtain or inspect any and all records, letters of recommendation, performance improvement data, or other materials deemed pertinent. The Credentials Committee, with input and advice by the appropriate subcommittee, shall summarize its findings in the form of a recommendation including a delineation of clinical privileges, which shall become a part of the application.

H. The Credentials Committee, with input and assistance by the appropriate subcommittee, shall forward the application to the Office of Chief Medical Officer (DMA) who shall obtain or inspect any and all records, letters of recommendation by peers, performance improvement data, or other materials deemed pertinent. The Office of Chief Medical Officer (DMA) shall summarize the findings in the form of a recommendation including a delineation of clinical privileges, which shall become a part of the application.

I. The Office of Chief Medical Officer (DMA) shall forward the completed application to the Medical Staff Executive Committee.

J. The Medical Staff Executive Committee shall review the completed application and prepare its written recommendation to become a part of the application. All recommendations to appoint must also specifically recommend the clinical privileges to be granted, which may be qualified by probationary conditions relating to such clinical privileges.

K. The Medical Staff Executive Committee shall forward its recommendation through the Associate Vice President for Medical Center Operations to the Credentials Committee authorized by the University Hospital Committee to act on its behalf.

L. At its next regular meeting, following receipt of the application from the Associate Vice President for Medical Center Operations, the Credentials Committee authorized by the University Hospital Committee to act on its behalf shall act upon the application. Once the , Credentials Committee acting on behalf of the University Hospital Committee approves, modifies, or disapproves the application as submitted by the Associate Vice President for Medical Center Operations, including the recommended delineation of

clinical privileges, it shall return the application to the Office of Chief Medical Officer (DMA), who shall notify the applicant in writing.

M. Upon receipt of the action of the University Hospital Committee on any application, the Office of Chief Medical Officer (DMA) shall send written notice to the Associate Vice President for Medical Center Operations, the Medical Staff Executive Committee, and the chair of the department concerned (chief of clinical service).

N. All actions of the Credentials Committee including the delineation of clinical privileges, shall be effective when taken, subject to review, ratification, and finalization by the University Hospital Committee at its next regularly scheduled meeting.

ARTICLE VI

CLINICAL PRIVILEGES

SECTION 1. Exercise of Privileges

Except as otherwise provided in these *Bylaws*, a member of the medical staff with clinical privileges at the Hospital shall have access to the Hospital to exercise only those clinical privileges specifically granted. Clinical privileges must be within the scope of any license, certificate, or other legal credential authorizing practice in Kentucky and consistent with any restrictions thereon and shall be subject to the rules and regulations of the clinical department and the authority of the department chair (chief of clinical service) and the medical staff. Each practitioner shall be assigned to the primary department in which clinical privileges are granted. In the event a practitioner receives a joint appointment, the practitioner shall apply for and, if granted, receive privileges in each department in which the practitioner is jointly appointed.

SECTION 2. Delineation of Privileges in General

A. Each applicant for appointment or reappointment to the medical staff must request the specific clinical privileges desired. All applications for clinical privileges, including modifications to existing privileges, must be supported by documentation of training and/or experience to demonstrate current competence.

B. Each member of the medical staff shall exercise only those clinical privileges specifically granted to that member by the Credentials Committee and ratified by the University Hospital Committee. Whenever patient needs exceed the limits of privileges granted, consultation is required.

C. Surgical procedures performed by dentists shall be under the overall supervision of the chief of surgery. A physician member of the medical staff shall be responsible for the treatment of any medical problem that may be present in a patient at the time of admission to the Hospital or that may arise during the hospitalization of the patient.

D. A member of an independent licensed practitioner category may exercise only those clinical privileges specifically granted by the Credentials Committee and ratified by the University Hospital Committee and may, subject to any licensure requirements or other legal limitations, exercise judgment within the areas of their professional competence. A member of a health-related profession shall be directly responsible to the relevant chief of clinical service and must be supervised during patient treatment by the physician or dentist attending the patient.

E. Medical staff members desiring joint appointments shall have their requests to perform specific patient services evaluated and specifically delineated by the department(s) and specialty division(s) within which the services of the medical staff member will be provided.

SECTION 3. Basis for Privileges Determination

Requests for clinical privileges shall be evaluated on the basis of the member's prior and continuing education, training, experience, demonstrated current professional competence and judgment, clinical performance, utilization practice patterns, current health status, and ability to exercise clinical privileges and responsibilities, with or without reasonable accommodations, the Hospital's capability to support the privileges requested, adequate professional liability insurance coverage, and the documented results of patient care and other quality review and monitoring that the medical staff deems appropriate.

SECTION 4. Proctoring

Except as otherwise determined by the Medical Staff Executive Committee with the approval of the Credentials Committee authorized by the University Hospital Committee to act on its behalf , all initial appointees to the medical staff and all members granted new clinical privileges shall be subject to a period of

proctoring. Each appointee or recipient of new clinical privileges shall be assigned to a department and division where performance of an appropriate number of cases, procedures, or clinical encounters as established by the Medical Staff Executive Committee or the department or division as the designee of the Medical Staff Executive Committee, as approved by the Credentials Committee authorized by the University Hospital Committee to act on its behalf shall be observed by the chair of the department or division, or designee, during a period of proctoring specified in the department's or division's rule and regulations, to determine suitability to continue to exercise the clinical privileges granted in that department or division. The exercise of clinical privileges in any other department or division shall also be subject to direct observation by that department's or division's chair or designee. The member shall remain subject to such proctoring until the Medical Staff Executive Committee has been furnished with:

A. a report (which may be verbal) by the chair of the department(s) and division(s) to which the member is assigned, or designee, describing the types and numbers of cases, procedures, clinical encounters observed, evaluation of the member's performance, and a statement (which may be verbal) that the applicant appears to meet all of the qualifications for supervised or unsupervised practice in that department or division and has discharged all of the responsibilities of medical staff membership; and

B. a report (which may be verbal) by the chair of the other department(s) and division(s) in which the clinical privileges initially granted in those departments, or designee, that the practitioner may exercise clinical privileges, describing the types and number of cases, procedures, clinical encounters observed, evaluation of the practitioner's performance, and a statement (which may be verbal) that the applicant has satisfactorily demonstrated the current competency and ability to exercise those privileges.

SECTION 5 Focused Review of Clinical Privileges

A. A Focused Review is a quality improvement and peer review activity that involves an intensive, but non-adversarial, review of a practitioner's performance to determine whether the practitioner meets the standard of care, or whether the practitioner may require additional education, training, or other appropriate action to improve performance and enhance quality of care and clinical outcomes. The emphasis in a Focused Review is on education. Its goal is to improve the practitioner's clinical performance, rather than discipline the practitioner. However, the results of a Focused Review may lead to Voluntary Remediation and/or Corrective Action, where warranted.

B. A Focused Review may be initiated under circumstances when a practitioner's clinical performance, including (but not limited to) current competence, clinical skill, technique or judgment are called into question, because of outcomes, mortality, morbidity, or other concern and questions are raised.

C. Focused Reviews may be initiated and conducted on the departmental or service levels. Focused Reviews also may be initiated and conducted by the Office of the Officer of the Chief Medical Officer (DMA), Credentials Committee, Medical Staff Executive Committee or by an *ad hoc* committee appointed by the Medical Staff Executive Committee. The review may include independent, external reviewers, when necessary or advisable. Focused Reviews usually will be retrospective, but could, where appropriate, be prospective and may involve review of medical records, as well as interviews, observation, and other measurement and assessment activities.

D. The Department Chair, Chief of Service, President of the Medical Staff, or the Office of Chief Medical Officer (DMA), as appropriate, will notify the practitioner that a Focused Review is being conducted. The practitioner will be invited and encouraged to participate actively. Because the emphasis is on education and improvement, cooperation by the practitioner is important. If the practitioner is uncooperative, a Focused Review may be terminated, and a request for Voluntary Remediation and/or investigation that could lead to Corrective Action may be made.

E. A Focused Review should be conducted promptly, but thoroughly. Generally, a Focused Review should be completed within 45 days, but it may be extended longer, on a case-by-case basis, when appropriate.

F. Upon conclusion of the Focused Review, a finding and recommendation will be made that the practitioner's performance is acceptable, or one that appropriate improvement activities are indicated, which may include (without limitation) further education, clinical "hands-on" training, monitoring, periodic meetings, second opinions, or other efforts to improve performance, reduce morbidity, mortality, errors and enhance quality care and clinical outcomes. The findings and recommendations will be included in a written report that will go to the Medical Staff Executive Committee, the Department Chairman or Service Chief, the Office of Chief Medical Officer (DMA) and the Credentials Committee. No report will be made to the National Practitioner Data Bank, unless the improvement activity involves a restriction of the ability of the practitioner to exercise clinical privileges.

G. Because a Focused Review is a quality improvement and peer review activity, all Focused Review records and reports shall be privileged and confidential.

SECTION 6. Temporary Privileges

A. Upon receipt of a complete application for appointment to the medical staff from a physician, dentist, or a member of a related health profession licensed to practice in the Commonwealth of Kentucky, which is waiting for the recommendation by the Medical Staff Executive Committee and approval by the Credentials Committee, as authorized by the University Hospital Committee to act on its behalf, the Office of Chief Medical Officer (DMA), or in absence, the President of the Medical Staff, may grant temporary privileges not to exceed 120 days, for good cause on a case-by-case basis, and not merely for administrative convenience, provided:

1. The Office of Chief Medical Officer (DMA), or in absence, the President of the Medical Staff, with assistance through the Medical Staff Office, verifies that the practitioner possesses an appropriate, current, and unrestricted medical or professional license without current or previously successful challenge to licensure; and that the practitioner has appropriate education, training, experience, current competence, judgment, and clinical skills to perform the clinical privileges requested; the practitioner has not voluntarily relinquished clinical privileges to avoid action arising out of quality concerns, been subject to involuntary limitation, reduction, denial, or loss of clinical privileges, and has not been voluntarily resigned membership in order to avoid action arising out of quality concerns or been subject to involuntary termination of medical staff membership at another organization. No action will be taken on a request for temporary privileges until such requirements are verified.

2. The Office of Chief Medical Officer (DMA), or the President of the Medical Staff, or the appropriate department or division chair has interviewed the applicant and has contacted at least two (2) persons who are qualified as peers and who have:

   a. worked with the applicant during the prior twelve (12) months;

   b. directly observed the applicant's professional performance over a reasonable period of time; and who

   c. provide reliable information regarding the applicant's current professional competence and character.

3. An inquiry is made to the National Practitioner Data Bank and the results have been evaluated; and

4. The applicant's department chair (chief of clinical services), after reviewing the applicant's file and attached materials, recommends granting temporary privileges.

In exercising such temporary privileges, the applicant shall act under the general supervision of the chair (chief of clinical service) of the department to which the applicant is assigned. The Office of Chief Medical Officer (DMA) shall forward the application in accordance with Article V, Section 3, and shall notify, in writing, the Associate Vice President for Medical Center Operations and the applicant of the specific temporary privileges granted and their duration.

B. Temporary privileges for the care of a specific patient may be granted to a physician or dentist licensed to practice in the Commonwealth of Kentucky who is not an applicant for membership to the medical staff, by the Office of Chief Medical Officer (DMA) or, in absence, by the President of the Medical Staff. Such temporary privileges may be granted only after the Office of Chief Medical Officer (DMA) or, in absence, President of the Medical Staff, with assistance through the Medical Staff Office, has:

1. Verified from appropriate licensing authorities, other institutions where the practitioner has active medical staff membership and privileges and from peer references, that the practitioner possesses an appropriate, current, and unrestricted medical or professional Kentucky license; and that the practitioner has appropriate education, training, experience, current competence, judgment, and clinical skills to perform the clinical privileges requested. No action will be taken on a request for temporary privileges until such requirements are verified. This verification process does not constitute, nor is it synonymous with, a completed credentialing and privileging process that the Hospital uses when credentialing members or prospective members seeking permanent privileges.

2. Received from the physician or dentist the signed acknowledgment that he or she received and read copies of the *Medical Staff Bylaws, Rules and Regulations*, *Behavioral Standards in Patient Care*, and the Medical Center's Corporate Compliance policy; and that he or she agrees to be bound by the terms thereof in all matters relating to their temporary privileges. The physician or dentist also shall

acknowledge that the granting of temporary privileges shall not confer membership status. Such temporary privileges shall be restricted to a period not to exceed thirty (30) days unless the Office of Chief Medical Officer (DMA) or President of the Medical Staff recommends a longer period for good cause.

C. Special conditions and requirements of supervision and reporting may be imposed by the department chair (chief of clinical service) on any physician or dentist granted temporary privileges, which may include the following:

1. If granted temporary privileges, the practitioner shall act under the supervision of the department or division chair (chief of clinical services) to which the practitioner has been assigned, and shall ensure that the chair or designee is kept closely informed as to the practitioner's activities within the Hospital.

2. Temporary privileges shall automatically terminate at the end of the designated period, unless earlier terminated by the Office of Chief Medical Officer (DMA), the f President of the Medical Staff or the Medical Staff Executive Committee, or unless affirmatively renewed.

3. Requirements for proctoring and monitoring may be imposed, as warranted and reasonable, on such terms as may be appropriate under the circumstances upon any practitioner granted temporary privileges.

4. Temporary privileges may be immediately terminated at any time by the Office of Chief Medical Officer (DMA) or by the President of the Medical Staff, who first shall notify the chair of the department or division or designee, if practicable, before terminating temporary privileges. In such cases, the appropriate department or clinical section chief or, in the chair's/chief's absence, the Office of Chief Medical Officer (DMA) or President of the Medical Staff shall assign a member of the medical staff to assume the responsibility for the care of such practitioner's patient(s). The wishes of the patient shall be considered in the choice of a replacement medical staff member.

5. A practitioner shall not be entitled to the procedural rights afforded by Article XI because a request for temporary privileges is refused or because all or any portion of temporary privileges are terminated or suspended.

6. All practitioners requesting or receiving temporary privileges shall be bound by the *Bylaws, Rules and Regulations*, policies of the medical staff, *Behavioral Standards in Patient Care*, and the Medical Center's Corporate Compliance Program.

SECTION 7. Emergency Privileges

A. In the case of an emergency (i.e., a condition in which serious permanent harm would result to a patient or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger), any physician or dentist to the degree permitted by the physician's or dentist's license and regardless of department or staff status or lack of it, shall be permitted and assisted to do everything possible to prevent serious permanent harm or to save the life of the patient, using every facility of the Hospital necessary, including calling for any consultation necessary or desirable. When an emergency situation no longer exists, such physician or dentist must request the privileges necessary to continue to treat the patient. In the event such privileges are denied or the physician or dentist does not desire to request privileges, the patient shall be assigned to an appropriate member of the medical staff.

B. In circumstances of disaster(s), in which the emergency management plan has been activated, the Associate Vice President for Medical Center Operations, Office of Chief Medical Officer (DMA) or President of the Medical Staff, or their designee(s) may grant emergency privileges to physicians, dentists, and health-related professionals (Licensed Independent Practitioners), in order to provide for adequate and appropriate staff during emergency disaster(s), with a means to privilege physicians, dentists or health related professionals (Licensed Independent Practitioners) who are qualified and volunteer their services during a disaster(s) but are not members of the medical staff.

1. Office of Chief Medical Officer (DMA), President of the Medical Staff, Associate Vice President for Medical Center Operations or their designee(s) will use their best efforts, depending upon the severity of the disaster, to verify the Kentucky License in following manor:

a) A current copy of the pocket Medical License and current valid drivers license or photo ID.
b) A hospital picture ID.
c) Kentucky Medical Licensure Board web site if access is available.
d) Kentucky Medical Directory.
e) ID that certifies the individual is a member of a Disaster Medical Assistance Team.
f) ID that certifies a state, federal, or municipal entity has granted the individual the authority to administer patient care under emergency circumstances.

g) Presentation by a current hospital or medical staff member who can vouch for the individual's identity.

2. Privileges will be in effect for only the duration of the emergency. Once the disaster(s) is under control their emergency privileges will expire at the discretion of the chief executive officer, President of the Medical Staff or their designee.

The responsible individual is not required to grant privileges to any individual and is expected to make such decisions on a case-by-case basis at his or her discretion.

Health-related professionals (Licensed Independent Practitioners) who are granted emergency privileges are limited to privileges within his/her own licensure and specialty. They will be assigned to a specific department relating to their specialty. They will report to that department chair or designee(s) for patient care assignments and supervision.

ARTICLE VII

CRITERIA FOR RECOMMENDATIONS FOR APPOINTMENT AND REAPPOINTMENT TO MEDICAL STAFF AND RECONSIDERATION

SECTION 1. Criteria for Appointment and Reappointment to Medical Staff

Whenever a department chair (chief of clinical service), President of the Medical Staff, the Medical Staff Executive Committee, or the University Hospital Committee is or are called upon to review an application for appointment or reappointment to the medical staff and to make a recommendation or to take action concerning the application, the applicant shall be evaluated on the basis of the applicant's education, training, experience, clinical performance, competence, and clinical judgment in the treatment of patients, ethics, conduct, attendance at medical staff meetings, participation in staff affairs, compliance with Hospital policies, compliance with *Medical Staff Bylaws* and *Rules and Regulations*, cooperation with Hospital personnel, use of Hospital facilities for patients, faithfulness in assigned department duties, relations with other practitioners, general attitude toward patients, compliance with *Behavioral Standards in Patient Care*, cooperation with the corporate compliance program, mental and physical abilities to carry out staff responsibilities, and any other areas of concern relevant to the practice of the applicant's profession.

SECTION 2. Reconsideration

A. At any time before a final action, any committee making a recommendation may reconsider and modify or rescind its recommendation as appropriate.

B. Whenever an applicant for appointment or reappointment receives notice that his/her application for staff membership has been rejected or recommended for rejection at any level or that the clinical privileges delineated by the Credentials Committee are at variance with those requested by the applicant, the applicant may request reconsideration of their application by an *ad hoc* committee. The *ad hoc* committee shall consist of three (3) members of the Medical Staff Executive Committee appointed by the Dean of the College of Medicine, three (3) members of the University Hospital Committee appointed by the University Hospital Committee, and three (3) members of the active medical staff appointed by the President of the Medical Staff. The request must be in writing and received within ten (10) business days following the applicant's receipt of notification. The applicant may request to be heard in their own behalf but without being represented by counsel.

C. The *ad hoc* committee shall reconsider the application and shall notify in writing the applicant and the decision-making person or body of its recommended action, which may be one of the following:

1. approval of the application for staff membership,
2. rejection of the application for staff membership,
3. further processing of a deferred application for staff membership,
4. continued deferral of an application for staff membership,
5. granting of all or part of the privileges requested by the applicant, or
6. denial of all or part of the privileges requested by the applicant.

D. The *ad hoc* committee's recommendation shall be promptly delivered to the University Hospital Committee which shall take action on it at its next regular meeting. If the application for appointment or reappointment or increase of clinical privileges is denied for quality reasons, the applicant shall be entitled to the procedural rights in Article X.

ARTICLE VIII

VOLUNTARY REMEDIATION / PRACTITIONER ASSISTANCE

It is in the best interest of the Hospital, through its medical staff, to enhance patient care quality and for issues or potential issues involving the clinical competency and/or conduct or behavior of practitioners to be identified early and, if possible, remedied in a productive manner. Depending on the particular circumstances presented, determined on a case-by-case basis, remediation may be sought by voluntary, non-confrontational, and informal means rather than by formal corrective or disciplinary action.

SECTION 1. Voluntary Remediation

A. Voluntary remediation may be appropriate when a problem or potential problem, though cause for concern, may or may not constitute grounds for formal corrective action and is of such a nature that voluntary measures can be taken to resolve it. Nothing in this article, however, limits or restricts in any way the taking of corrective action at any time when warranted, nor shall voluntary remediation be interpreted as a mandatory first step or pre-condition to taking corrective action.

B. Voluntary remediation is an authorized peer review activity of the Hospital and its medical staff. It can, depending on circumstances, function through a variety of ways, including but not limited to, informal interviews between a practitioner with the Office of Chief Medical Officer (DMA), President of the Medical Staff (or designee) and/or the Medical Staff Executive Committee. It may involve the use of outside consultants, reviewers, medical practitioners, counselors, therapists, mediators, and monitors. Those participating in voluntary remediation shall be deemed agents of the Hospital. Voluntary remediation sessions shall not constitute a formal corrective action hearing. No attorneys shall attend any voluntary remediation session. Voluntary remediation sessions, those participating in them, and the data presented are considered to be peer review protected by the confidentiality and immunity provisions under these *Bylaws,* as well as by federal and Kentucky law.

C. Any of the following — the Office of Chief Medical Officer (DMA), President of the Medical Staff, or the Associate Vice President for Medical Center Operations (or designee) or the chair (chief of clinical services) or other physician may request voluntary remediation.

D. Voluntary remediation, which may include but is not limited to, education, training, monitoring, psychiatric and/or medical evaluation, counseling, treatment, or therapy, may be continued, as warranted, with the goal, if reason exists, of having the practitioner voluntarily sign a remedial action plan that outlines what steps that physician needs to take to remedy the problem. The remedial action plan may also contain language providing for corrective action if the terms of the voluntary remedial action plan are violated.

E. A copy of the remedial action plan shall be kept in the practitioner's credentialing file. As a product of peer review, it shall be marked "Confidential Peer Review Document" and shall not be disclosed or released to any party without written authorization by the practitioner, unless disclosure is required by applicable law.

F. Because voluntary remediation does not constitute a "professional review activity," as described by the Health Care Quality Improvement Act of 1986, it shall not be deemed a reportable event to the State Medical Board of Kentucky or to the National Practitioners Data Bank.

SECTION 2. Practitioner Assistance

A. The Hospital and its medical staff recognize that, on occasion, a practitioner may become impaired. It is the intent to promptly identify, treat, and correct impairment or a condition that may lead to impairment in a confidential, dignified, and sensitive manner.

B. When impairment is reasonably suspected, the Office of Chief Medical Officer (DMA) or in absence the President of the Medical Staff or designee shall investigate the issue. The Practitioner Effectiveness Committee may assist the Office of Chief Medical Officer (DMA) or President of the Medical Staff in the evaluation process.

C. Nothing in this Article shall limit or restrict, in any way, the taking of corrective action, at any time when warranted, nor shall referral to the Practitioner Effectiveness Committee be interpreted as a mandatory first step or pre-condition to taking corrective action.

D. Notwithstanding this Article, a practitioner's violation of the terms of an aftercare agreement shall result in automatic suspension or termination, without the right to a hearing or appeal, as provided in Article XI.

ARTICLE IX

AUTOMATIC SUSPENSION AND TERMINATION

SECTION 1. Automatic Suspension and Termination

A. Automatic suspension or termination, as warranted, may be imposed upon a medical staff member by the Office of Chief Medical Officer (DMA) or in absence the President of the Medical Staff whenever:

1. The medical staff member, after receipt of a warning of delinquency for failure to complete medical records within thirty (30) days of patient's discharge (See *Rules and Regulations*, Medical Records), fails to complete the records. Such automatic suspension shall be temporary and effective until the records are complete and need not be followed by a written request for corrective action.

2. The medical staff member, after receipt of a warning of delinquency for failure to abide by the medical staff policies regarding management of diagnostic radiology films, pictures, and other records, persists in failure to abide by the policies and procedures for the maintenance and integrity of radiologic records. Such automatic suspension will be temporary and effective until the delinquency is corrected and need not be followed by a written request for corrective action.

3. The State Board of Medical Examiners, the State Board of Dentistry, or other appropriate state licensing agency revokes or suspends or restricts a medical staff member's license to practice or places such medical staff member on probation. Such automatic suspension/termination shall be effective at least until the medical staff member regains a full and unrestricted license to practice .

4. The medical staff member's faculty or employment status at the University is terminated. The medical staff member shall notify the Office of Chief Medical Officer (DMA) or in absence the President of the Medical Staff whenever the medical staff member's faculty or employment status is terminated. In the case of a full-time faculty member changing to a voluntary or part-time faculty member, their medical staff membership shall automatically change from active to associate or voluntary, and the Office of Chief Medical Officer (DMA) or in absence the President of the Medical Staff(or designee) shall notify the relevant department chair (chief of clinical service), the relevant Dean, the Associate Vice President for Medical Center Operations, and the Executive Vice President for Health Affairs.

5. The medical staff member violates the terms of an aftercare agreement.

6. If a medical staff member has been indicted for a felony or other criminal act related to, or arising out of the practice of medicine, the medical staff member's membership may be automatically suspended. If a medical staff member has been convicted of, or pleads no contest to, a felony or crime arising out of the practice of medicine, that member shall be automatically suspended or terminated.

7. The medical staff member has been deemed "ineligible" to participate in Medicare, Medicaid or any federal health program.

B. Notification of the automatic suspension or termination must be made in writing to the medical staff member, and the relevant department chair (chief of clinical service). When circumstances warrant, particularly in order to protect the safety, health and welfare of patients, members of the medical staff, and others, notice may be oral, provided that it is followed up in writing within one business day.

C Office of Chief Medical Officer (DMA) , the President of the Medical Staff, (or their designees,) and/or chief of clinical services (department chair) will arrange for appropriate alternate coverage by a member of the medical staff to patients of a member who has been automatically suspended or terminated, so that continuity of care is not interrupted or compromised.

SECTION 2. The Right to a Hearing or Appeal under Article XI.

A medical staff member who has been subjected to automatic suspension or termination under this article shall not be entitled to any hearing or appeal, including that under Article XI of these *Bylaws*.

The Office of Chief Medical Officer (DMA) or the President of the Medical Staff (or designees) shall notify: (a) the National Practitioner Data Bank for automatic suspensions of more than thirty (30) days and automatic terminations except those based solely upon termination of the faculty appointment, and (b) the appropriate state licensure board under the laws of the Commonwealth of Kentucky.

ARTICLE X

CORRECTIVE ACTION

Corrective Action is a peer review function performed by the medical staff on behalf of the Hospital and its patients in order to assure clinical competence and appropriate professional behavior. Those persons involved in the corrective action process, including those who request corrective action in good faith, those who

investigate, deliberate, recommend and take final action, and those who testify or otherwise present evidence in connection with corrective action are entitled to immunity, and corrective action reports, supporting documents and proceedings are privileged and confidential.

SECTION 1. Action Without Summary Suspension

A. Request for Corrective Activity Investigation.

Whenever any member of the medical staff, including, without limitation, the Office of Chief Medical Officer (DMA) , President of the Medical Staff,(or designees), the chief of clinical service (department chair), the chair of any quality committee, any member of the Medical Staff Executive Committee, house officers, nursing, independent licensed practitioners, and other staff personnel, as well as the Associate Vice President for Medical Center Operations or member of the University Hospital Committee, who has reason to believe that grounds exist may request or seek a request for a corrective activity investigation.

B. Grounds

A request for corrective disciplinary or clinical concern action may be made, based on information available at the time of the request, where reasonable belief of any of the following grounds exist:

1. Clinical deficiencies including the failure by an affected practitioner to meet the Hospital's standards of quality care, and/or *Behavioral Standards in Patient Care*, which may be considered in terms of frequency and/or severity.

2. Professional conduct, behavior, or impairment not in the best interest of quality patient care, or a condition that places the affected practitioner or others at a risk of harm.

3. Behavior disruptive to the orderly operation of the Hospital, which may include, but is not limited to, verbal and/or physical actions, threats, or other inappropriate behavior directed against patients, physicians, nurses, other Hospital personnel, or the public.

4. Recurrence of clinical and/or behavior problems. For purposes of establishing recurrence and/or pattern of problems, attention should focus on incidents most proximate in time to the request for corrective action, but other more remote incidents may also be considered as relevant background.

5. Violation of the terms and conditions of any corrective action plan or remedial action plan.

6. Violation of the Medical Center's Corporate Compliance Program.

C. Form of Request

A written request identifying or describing any act, incident, problem, deficiency, or concern reasonably believed to constitute grounds shall be signed by the President of the Medical Staff, the Office of Chief Medical Officer (DMA) , chief of service (departmental chair), the Associate Vice President for Medical Center Operations, or member of the University Hospital Committee.

D. Fact-Finding Investigation

Depending on the nature of the suspected act, incident or problem that resulted in the request for corrective action, the Office of Chief Medical Officer (DMA) or in absence the President of the Medical Staff may conduct a fact-finding investigation or may appoint a designee or *ad hoc* fact-finding committee, who may or may not be members of the medical staff, to investigate the matter. The designee or *ad hoc* fact-finding investigation committee shall review records and documentary material that are relevant or that could lead to relevant facts, including, but not limited to, medical records, quality assessment data, quality assessment/incident reports, complaints, and reports.

The designee or *ad hoc* fact-finding investigation committee may consult with third-party reviewer/consultant(s) regarding the investigation. The designee or fact-finding investigation committee may interview any person with knowledge of any deficiency, problem, conduct, behavior, or incident serving as grounds for the request for corrective action. These interviews shall be confidential.

The designee or *ad hoc* fact-finding investigation committee shall notify and conduct an interview with the affected practitioner, unless the affected practitioner declines. This interview is informal and does not constitute a hearing. The affected practitioner shall have an opportunity to discuss the subject matter of the request for corrective action

The designee or *ad hoc* fact-finding investigation committee shall make a written report of its investigation to the Medical Staff Executive Committee. The report shall indicate whether, based on the information obtained and/or reviewed during the investigation, sufficient factual support exists for

corrective action to be considered, but it shall not make a specific recommendation as to what corrective action, if any, should be taken. The report may inform the Medical Staff Executive Committee of additional incidents, deficiencies, problems, or other relevant information learned in the course of investigation. If the investigation concludes there is no basis for the request for corrective action, this should be reported to the Medical Staff Executive Committee, which may dismiss the request.

The report shall include any information obtained and/or reviewed by designee or *ad hoc* fact-finding investigation committee.

The report shall be delivered to the Medical Staff Executive Committee within thirty (30) business days from the date the request was received, unless the designee or *ad hoc* fact-finding investigation committee informs the Office of Chief Medical Officer (DMA) or President of the Medical Staff that it requires an additional thirty (30) days to complete the investigation because further information is reasonably requested.

E. Recommendation

The Medical Staff Executive Committee shall determine what action, if any, is to be taken and notify the affected practitioner.

F. Corrective Action Options

The following forms of corrective action are available to be taken against any member of the medical staff, including but not limited to:

1. oral or written warning to medical staff member;
2. Focused Review

3. formal written reprimand to medical staff member with notice to their immediate superior;

4. summary suspension of privileges;

5. putting the affected practitioner on probation according to the terms and conditions stated in a written corrective action plan, which may include but is not limited to:

    a. Focused Review
    b. Education/training/re-training.
    c. Consultation or second opinion
    d. Monitoring/proctoring
    e. Retrospective review
    f. Psychiatric/psychological evaluation, counseling, treatment therapy.

6. Reduction of some or all clinical privileges for less than thirty (30) days;

7. Reduction of some or all clinical privileges for more than thirty (30) days;

8. Suspension from the medical staff for less than thirty (30) days;

9. Suspension from the medical staff for thirty (30) days or more;

10. Revocation of medical staff appointment and/or privileges.

The Office of Chief Medical Officer (DMA) or President of the Medical Staff or (or designee) shall notify: (a) the National Practitioner Data Bank revocations, suspensions, or other limitations placed on clinical privileges that last for more than thirty (30) days, and (b) the appropriate state licensure board under the laws of the Commonwealth of Kentucky.

SECTION 2. Corrective Action with Summary Suspension

1. Grounds

Whenever reasonable belief exists that immediate action must be taken in the interest of quality care or to protect the safety of patients, other practitioners, Hospital employees, the affected practitioner, or others because of the risk of harm, the Office of Chief Medical Officer (DMA) or President of the Medical Staff, (or designee), the chief of clinical service (department chair), the Associate Vice President for Medical Center Operations, the Medical Staff Executive Committee, or the University Hospital Committee shall each have the authority to suspend all or any portion of the affected practitioner's clinical privileges

and/or medical staff appointment. Summary suspension may be instituted at any time, including during the pendency and processing of a request for corrective action investigation, described in this Article.

2. Immediate Effect and Coverage Arrangement

   Summary suspension shall be effective immediately upon imposition. The Office of Chief Medical Officer (DMA) or President of the Medical Staff (or designee) and/or chief of clinical services (department chair) shall arrange for appropriate alternate coverage by a member of the medical staff to patients of the affected practitioner, so that continuity of care is not interrupted or compromised.

3. Notice

   Notice to the affected practitioner may first be made orally but must be in writing and delivered to the affected practitioner in person or by certified mail within twenty-four (24) hours. The notice shall identify or describe any act, incident, problem, deficiency, or risk that is reasonably believed to constitute grounds for summary suspension and shall inform the affected practitioner of the right to request a hearing within twenty-one (21) business days from the date the practitioner first is notified that summary suspension has been imposed. A copy of the written notice shall be delivered as soon as practicable to the Medical Staff Executive Committee, the chief of clinical service (department chair), and the Associate Vice President for Medical Center Operations.

4. Request for Summary Suspension Reconsideration

   The affected practitioner whose privileges and/or appointment have been summarily suspended may request a reconsideration before the Office of Chief Medical Officer (DMA) or President of the Medical Staff by delivering a written request to the Office of Chief Medical Officer (DMA) or President of the Medical Staff within twenty-four (24) hours from the date and time the affected practitioner first received written notice that their privileges and/or appointment have been summarily suspended.

5. Corrective Action Options for a Practitioner Who has Been Summarily Suspended

   An affected practitioner who has been summarily suspended under this section shall be subject to the same corrective action options, which may be recommended at the hearing and acted upon by the Board, that are described in this Article.

6. Summary Suspension Reporting

   Any summary suspension shall be reported to appropriate licensure board under the laws of the Commonwealth of Kentucky by the Office of Chief Medical Officer (DMA) or President of the Medical Staff (or designee), and if in effect for thirty (30) days or longer, shall be reported to the National Practitioner Data Bank by the Office of Chief Medical Officer (DMA) or President of the Medical Staff (or designee).

ARTICLE XI

PROFESSIONAL REVIEW ACTIVITY HEARING AND APPEAL

A. Right to Hearing

   1. No Right to Hearing. The following practitioners shall not be entitled to a professional review activity hearing:

      a. An applicant or practitioner whose application, faculty appointment, and/or privileges has lapsed, expired, or been automatically suspended or terminated.

      b. An applicant who does not have their application for appointment and/or clinical privileges granted because that applicant does not meet the minimum prescribed training, education, and experience requirements necessary to qualify for appointment and/or to exercise privileges.

      c. An affected practitioner for whom corrective action has been imposed that does not revoke, restrict, or limit the practitioner's medical staff membership and/or ability to exercise clinical privileges for (thirty) 30 days or more and is, thus, not reportable to the applicable licensure board under the laws of the Commonwealth of Kentucky, nor the National Practitioner Data Bank, according to the Health Care Quality Improvement Act of 1986 and the regulations promulgated thereunder, as each may be amended from time to time.

   2. Right to a Professional Review Activity Hearing. The following practitioners shall be entitled to request a professional review activity hearing:

a Any practitioner whose appointment or reappointment to the medical staff has been denied because of quality and/or behavioral reasons or concerns.

b. Any practitioner whose clinical privileges have been curtailed, summarily suspended, revoked, restricted, or
denied because of quality and/or behavioral reasons or concerns for thirty (30) or more days.

c. Any practitioner who has received any adverse corrective action recommendation from the Medical Staff Executive Committee that would affect that practitioner's medical staff membership and/or ability to exercise clinical privileges (thirty) 30 days or more and, if imposed, constitute a "professional review action" reportable to the National Practitioner Data Bank, according to the Health Care Quality Improvement Act of 1986 and the regulations promulgated thereunder, as each may be amended from time to time.

B. Request for a Professional Review Activity Hearing

1. The affected practitioner must request in writing a professional review activity hearing. The request must be delivered to the Medical Staff Executive Committee through the Office of Chief Medical Officer (DMA) or President of the Medical Staff (or designee) within thirty (30) calendar days from the date notified of an action that gives rise to a right to a professional review activity hearing.

2. Failure by the affected practitioner to request a professional review activity hearing in writing within the time required above shall constitute a waiver.

C. Scheduled Professional Review Activity Hearing

1. A professional review activity hearing shall be scheduled no early than thirty (30) days and no later than sixty (60) days following receipt of the request for professional review activity hearing by the affected practitioner.

2. The Medical Staff Executive Committee shall notify the affected practitioner of the date, time, and place of the scheduled professional review activity hearing.

3. Either the affected practitioner or the Medical Staff Executive Committee may, for good cause, request a continuance of the professional review activity hearing. Both parties shall cooperate in good faith in re-scheduling the hearing at a mutually convenient
time.

D. The Hearing Body

1. The Medical Staff Executive Committee, or a hearing panel appointed by it, shall conduct the hearing. Members shall be entitled to all protection and immunity afforded by federal and state law.

2. No member of the Medical Staff Executive Committee, or a hearing panel appointed by it, shall be in direct competition with the affected practitioner.

E. Hearing Officer

1. The Medical Staff Executive Committee may appoint an independent attorney, who is not affiliated with the University or the Hospital, but who is familiar with Medical Staff hearing procedures, to act as a hearing officer for purposes of conducting the hearing process.

2. The hearing officer may answer procedural questions and other questions as related to these *Bylaws* and federal and state legal requirements, but the hearing officer shall not vote or otherwise participate in any deliberation (other than to answer procedural questions by hearing panel members) resulting in a recommendation made.

F. Exchange of Exhibits and Witness Lists

1. The affected practitioner and the Medical Staff Executive Committee or hearing panel shall exchange proposed exhibit and witness lists as soon as reasonably practicable, but no later than five (5) business days prior to the scheduled hearing. Each party shall inform the other of any changes in the exhibit or witness lists prior to the hearing.

2. Documents, if necessary, may be reproduced, provided that reasonable precautions are taken to ensure their confidentiality since these documents shall be considered matters of peer review.

G. Due Process and Fairness Rights

1. The professional review activity hearing is a confidential peer review action that shall be closed to the public.

2. The affected practitioner has the right to be present at the professional review activity hearing. Failure to be present without good cause shall constitute a waiver to the right of a professional review activity hearing.

3. The affected practitioner requesting the hearing shall be entitled to be represented at the hearing by an attorney or any other person of the practitioner's choice. The attorney or other person representing the practitioner may participate fully in the hearing.

4. The Office of Chief Medical Officer (DMA) or President of the Medical Staff (or designee), who shall present the case on behalf of the Hospital and its medical staff, shall be represented by an attorney.

5. Both parties shall have the opportunity to submit written memoranda at the beginning and at the conclusion of the professional review activity hearing.

6. Both parties shall have the opportunity to make opening statements and closing arguments.

7. Both parties shall have the opportunity to introduce written exhibits and testimony of witnesses in the form of reliable reports and/or direct and cross examination, which may include rebuttal and impeachment. Formal rules of evidence that would apply in a court of law need not be strictly followed; however, documents and testimony should be relevant and may be excluded by the hearing officer if not relevant or helpful or if duplicative.

8. The Hospital, through the Office of Chief Medical Officer (DMA) or President of the Medical Staff (or designee), shall proceed first in the presentation of the case, unless otherwise agreed by the parties and the Medical Staff Executive Committee.

9. The Medical Staff Executive Committee may ask questions of both parties at any time.

10. The burden of proof of showing, by a preponderance of evidence, that the corrective action is not warranted shall rest with the affected practitioner.

11. A record, by stenographic or audio means, shall be made of the entire professional review activity hearing.

H. Recess and Need for Additional Information

1. It is the intent to complete a thorough and fair professional review activity hearing in as few sessions and as quickly as practicable unless circumstances and fairness warrant the need for additional sessions and time.

2. The chair of the Medical Staff Executive Committee or hearing panel may recess the hearing and reconvene the same with fifteen (15) days for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation, all without special notice.

I. Deliberation and Report

1. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed. The Medical Staff Executive Committee or hearing panel may, at a time convenient to itself, conduct its deliberations outside the presence of the affected practitioner for whom the hearing was convened.

2. Within fifteen (15) calendar days of the final adjournment of the hearing, the Medical Staff Executive Committee or hearing panel shall make a written report and recommendation to the University Hospital Committee. Such report and recommendation shall include a statement of the basis for the recommendation. The report may recommend confirmation, modification, or rejection of the adverse action. A copy of the report and recommendation shall be sent to the affected practitioner at the same time it is forwarded to the University Hospital Committee.

3. The affected practitioner shall have fifteen (15) calendar days from the date the practitioner receives a copy of the report and recommendation to submit a written appeal to the University Hospital Committee with a copy to the Medical Staff Executive Committee, which may submit a written reply to the affected practitioner's written appeal.

J. Final Action by the University Hospital Committee

1. Within thirty (30) calendar days after receipt of the report and recommendation, the University Hospital Committee shall meet at a regular or special meeting to consider the report and

recommendation, as well as the affected practitioner's written appeal and the Medical Staff Executive Committee's written reply, and render a written decision in the matter, including a statement of the basis for the University Hospital Committee's decision, and shall forward a copy of its decision to the Associate Vice President for Medical Center Operations for transmittal to the practitioner for whom the hearing was held. The decision by the University Hospital Committee is final.

2. Any reporting to the National Practitioner Data Bank and/or applicable licensure board under the laws of the Commonwealth of Kentucky shall be made by the University Hospital Committee through the Office of Chief Medical Officer (DMA) or President of the Medical (or designee).

ARTICLE XII

PRESIDENT OF THE MEDICAL STAFF

SECTION 1. Qualifications and Election

A. President of the Medical Staff
The President of the Medical Staff shall be a member of the active medical staff. One or more qualified and competent candidates for the position of President of the Medical Staff shall be nominated by a committee consisting of the Executive Vice President for Health Affairs, College of Medicine Dean, Associate Vice President for Medical Center Operations, and Chief Medical Officer. The nominating committee will in turn present a slate of candidates to the medical staff for preliminary endorsement. Those candidates who receive endorsement from at least 20 members of the medical staff who are eligible to vote will also appear on the ballot, which will be presented to the medical staff at a meeting held for this purpose. No nominations will be made from the floor. Election will be by written ballot. The President of the Medical Staff will be elected by a majority vote.

B. Medical Staff Executive Committee Members at Large
The Medical Staff Executive Committee Members at Large shall be members of the active medical staff who are not Medical Staff Executive Committee members or their designee, except for previously elected Members at Large. Qualified and competent candidates shall be nominated by a committee consisting of the Executive Vice President for Health Affairs, College of Medicine Dean, Associate Vice President for Medical Center Operations, Chief Medical Officer, and President of the Medical Staff. The nominating committee will in turn present a slate of candidates to the medical staff for preliminary endorsement. Those candidates who receive endorsement from at least 20 members of the medical staff who are eligible to vote will also appear on the ballot, which will be presented to the medical staff at a regular or special meeting held for this purpose which may be concurrent with the election for President of the Medical Staff. No nominations will be made from the floor. Election will be by written ballot. The candidate(s) with the greatest and second greatest number of votes (when two vacancies) will be elected.

SECTION 2. Term of Office, Evaluation and Removal

A. The President of the Medical Staff will be elected to a two-year term. The election described in article XII section 1 will be held soon after the first year of the current Presidential term. The individual so elected will serve as President-Elect for the balance of the current Presidential term is completed, before assuming the duties of President of the Medical Staff. Candidates are eligible for a maximum of two terms.

B. The Members at Large will be elected to a two-year term, and are eligible for re-election.

C The Dean, Chief Medical Officer, Associate Vice President for Medical Center Operations, and Medical Staff Executive Committee shall periodically review and evaluate the duties, activities, performance, accomplishments, and appointment of the President of the Medical Staff. Such review shall be completed at least annually.

D. Removal of officers

Any officer of the Medical Staff may be removed from office for valid cause, including, but not limited to, gross neglect or misfeasance in office, or serious acts of moral turpitude. Recall of an elected Medical Staff Officer may be initiated by the Medical Staff Executive Committee or shall be initiated by a petition signed by at least forty members of the Medical Staff. Recall shall require a special meeting of the Medical Staff to be called for that purpose. Recall shall require a majority of Medical Staff members who return valid mail ballots within the allotted time period for response.

SECTION 3. Vacancies in Office

A. President of the Medical Staff

1. In the event the President of the Medical Staff should be temporarily unable to fulfill the duties of the office for a period of no more than four (4) months, the duties shall be assumed by President-Elect of the Medical Staff (when applicable). When a President-Elect is not identified, the Chief Medical Officer will assume the duties of the President of the Medical Staff..
2. In the event the position becomes permanently vacant, President-Elect of the Medical Staff will fill the remaining unexpired term of the President. The term of President shall not exceed 3 years after vacancy. If the unexpired term is equal to or greater than a year, then after one year a President-Elect will be chosen by election as described in Article XII section 1 who will serve as such for before assuming duties of President after one year. When a President-Elect is not identified, the Chief Medical Officer will assume the duties of the President of the Medical Staff until an election can be held.

Members at Large

In the event the position becomes permanently vacant, a new member will be elected as described in section 1 B for a full 2 year term.

SECTION 4. Duties of the President of the Medical Staff

The President of the Medical Staff shall serve as the chief administrative officer of the medical staff. Duties of the President of the Medical Staff include, but are not limited to:

A. acting in coordination and cooperation with the Associate Vice President for Medical Center Operations in all matters of mutual concern within the Hospital;

B. serving as a voting member and presiding as chair of the Medical Staff Executive Committee;

C. calling and being responsible for the agendas for all regular and special meetings of the medical staff and the Medical Staff Executive Committee;

D. serving as *ex officio* member (without vote) on all other medical staff committees and oversees that committees regularly and appropriately report to the Medical Staff Executive Committee;

E. having oversight responsibility for the application and enforcement of *Medical Staff Bylaws* and *Rules and Regulations*, for the implementation of corrective action where indicated, and for the medical staff's compliance with procedural safeguards in all instances where corrective action has been requested against a practitioner;

F. annually appointing committee chair and committee members to all standing, special, and multidisciplinary medical staff committees except the Medical Staff Executive Committee, and elected or ex-officio members of Medical Staff Committees;

G. reporting the views, policies, needs, and grievances of the medical staff directly to the University Hospital Committee and/or to the Associate Vice President for Medical Center Operations;

H. having oversight responsibility for assuring ethical conduct and acceptable professional behavior of members of the medical staff, and enforcing bylaws, rules, regulations, policies, and procedures including adherence to Hospital policies, *Behavioral Standards in Patient Care*, and the Medical Center's Corporate Compliance Program as applicable to practitioners;

I. having oversight responsibility for continuing educational activities of the medical staff;

J. having oversight responsibility for promoting interdisciplinary communication among medical staff departments and services, and other Hospital committees and services in order to improve operations, systems and care;

K. being the speaker for the medical staff in its external professional and public relations;

L. delegating duties and activities as deemed necessary and appropriate.

ARTICLE XIII

ORGANIZATIONAL STRUCTURE AND OPERATION

SECTION 1. Departmental Organization

The direct patient care segment of the University Hospital administrative organization shall be structured parallel to the major clinical activities of the Medical Center. The clinical departments shall be as follows:

Anesthesiology	Orthopedic Surgery
Dentistry	Pathology
Diagnostic Radiology	Pediatrics
Emergency Medicine	Physical Medicine & Rehabilitation
Family & Community Medicine	Preventive Medicine & Environmental Health
Internal Medicine	Psychiatry
Neurology	Radiation Medicine
Obstetrics/Gynecology	Surgery
Ophthalmology	University Health Services

SECTION 2. Functions of Departments

Subject to the authority of the Medical Staff Executive Committee and University Hospital Committee, departments/services shall perform the following delegated functions:

A. oversee the provision, evaluation, and improvement of quality patient care and periodically report to the Medical Staff Executive Committee;

B. require and provide appropriate continuing medical and professional education of practitioners, residents, medical students, health-related professional staff members, nursing, and other health personnel; and

C. review and recommend for approval by the Medical Staff Executive Committee and University Hospital Committee rules, regulations, policies, and standards regarding qualifications and requirements for determining current competence, credentialing, governing, promoting effective interdisciplinary communication and function, and governance. These recommendations; which must be consistent with these *Bylaws, Rules and Regulations*; medical staff policies; *Behavioral Standards in Patient Care*; and Hospital rules, regulations, and policies; shall not be effective until reviewed and approved by the Medical Staff Executive Committee and the University Hospital Committee.

SECTION 3. Chiefs of Services/Chairs

A. Each chief of service shall be board-certified or demonstrate equivalent competence and shall be a member in good standing of the active medical staff.

B. Chiefs of the clinical services within the Hospital shall usually be those appointed as chair of the respective departments, and/or divisions, in the Colleges of Medicine and Dentistry with concurrence of the Medical Staff Executive Committee and confirmation by the University Hospital Committee. In unusual circumstances, an individual may be made chief of a clinical service who is not a department or division chair. Such appointments shall be made by the Deans of the specific colleges, subject to approval by the Medical Staff Executive Committee and the University Hospital Committee, in accordance with the selection qualification criteria and process described in the University governing regulations.

C. Every person appointed to be a chief of service and/or department chair shall, prior to beginning service, undergo an orientation and training, at which time duties, responsibilities, and expectations of the office shall be reviewed.

SECTION 4. Duties of the Chief of Service/Department Chair

The chiefs of services/department chair shall have corporate responsibility for the care and treatment of the patients in their departments. Responsibilities of chief of service/department chair includes:

A. Membership on the Medical Staff Executive Committee.

B. All clinically related activities of the department to include:

1. Continuous assessment and improvement of the quality of care and safety as well as services provided.

2. Recommending to the Medical Staff Executive Committee clinical privileges for each member of the department.

3. Continuous surveillance of the professional performance of all individuals in the department who have delineated clinical privileges.

4. Recommending to the medical staff criteria for clinical privileges relevant to the care provided in the department.

5. Determining the qualifications and competence of department or service personnel who are not licensed practitioners and who provide patient care services, unless otherwise provided for by the Hospital.

C. All administratively related activities of the department to include:

1. Acting as the presiding officer at departmental meetings.

2. Oversight responsibility for education and research programs in the department.

3. Orienting staff to *Medical Staff Bylaws, Rules and Regulations*; Hospital policies, *Behavioral Standards in Patient Care*, and the Medical Center's Corporate Compliance Program as applicable to practitioners; and enforcing bylaws, rules, regulations, policies, and procedures within the department.

4. Integrating the department into the primary functions of the Hospital.

5. Coordinating and integrating interdepartmental and intradepartmental services.

6. Participating in every phase of administration of the department through promoting interdepartmental and interdisciplinary communication including, without limitation, cooperation with nursing staff and the Hospital Administration in matters affecting patient care, including personnel, supplies, special regulations, standing orders, and techniques.

7. Assessing and recommending to the Medical Staff Executive Committee or the Hospital, through the President of the Medical Staff or Associate Vice President for Medical Center Operations, off-site sources of needed patient care service not provided by the department and/or the Hospital or Kentucky Clinic.

8. Recommending a sufficient number of qualified and competent persons to provide care and service.

9. Maintaining quality control programs as appropriate.

10. Oversight to ensure that members of the department or service receive appropriate continuing medical education.

11. Considering appointing an associate chief of service who shall, in case of the chief of service's incapacity or absence from the community, assume the duties of chief of service. This associate shall be identified to the Dean, the President of the Medical Staff, and the Associate Vice President for Medical Center Operations. The associate chief shall be the only acceptable alternate to attend Medical Staff Executive Committee meetings.

SECTION 5. Term of Office, Evaluation, and Removal

The term of office shall be in accordance with the terms prescribed in the University's governing and administrative regulations.

SECTION 6. Vacancies

In the event a chief of service is temporarily unable to fulfill the duties of office, such duties shall be assumed by the associate chief of service. In the event the position becomes permanently vacant, the associate chief of

service shall serve as acting chief of service until such time as a new chief of service is appointed according to the procedure described in Section 3.

ARTICLE XIV

MEDICAL STAFF EXECUTIVE COMMITTEE

SECTION 1. Medical Staff Executive Committee

There shall be an executive committee of the medical staff called the Medical Staff Executive Committee .

SECTION 2. Composition
The Medical Staff Executive Committee shall consist of the following:

President of the Medical Staff (Chair)
President-Elect of the Medical Staff (when applicable)
Chiefs of clinical services (or their designee) as defined in Article XIII.
Two elected at large medical staff members (see Article XII, section 1)
Ex Officio (without vote)
- Dean, College of Medicine
- Associate Vice President for Medical Center Operations (Secretary)
- Chief Medical Officer
- Director of Medical Affairs
- Medical Directors nominated by the President of the Medical Staff or Chief Medical Officer
- Chief operating officer of the Group Practice Governance Council
- Director of the Lucille Parker Markey Cancer Center
- ACGME Designated Institutional Official
- Residency Director elected biannually by the GME committee
- Chairperson of the Chief Resident forum
- Director of Nursing, University Hospital
- Director of Pharmacy, University Hospital
- Dean, College of Nursing
- Dean, College of Dentistry
- Associate Dean for Veterans Affairs

SECTION 3. Functions

A. The Medical Staff Executive Committee is charged with the delegated responsible from the University Hospital Committee for the self-governing the members of the Medical Staff, and for overseeing the performance of clinical programs including the quality, safety and efficiency of care and treatment, as well as the coordination of activities between medical staff and Hospital departments and services to promote communication and improve function and clinical outcomes. The Medical Staff Executive Committee is empowered to transact business on behalf of the medical staff and to act for the medical staff.

The Medical Staff Executive Committee shall receive and act on reports and recommendations from medical staff committees, clinical departments, and assigned activity groups. The Medical Staff Executive Committee shall be responsible for making recommendations on matters pertaining to medical staff and related issues directly to the University Hospital Committee for its approval.

B. Recommendations shall include, but not be limited to:

1. The medical staff structure relating to organization, self-governance, and the performance of care and services by practitioners with privileges

2. Assisting the election of the President of the Medical Staff who represents the Medical Staff before the University Hospital Committee..

3. The mechanism used to review credentials and to delineate individual practitioner privileges.

4. Granting medical staff membership (initial appointment and reappointment).

5. The specific delineation of clinical privileges for each eligible practitioner, based on demonstrated competency and performance review.

6. The participation of the medical staff in organization performance improvement, risk management and compliance activities.

7. Mechanisms for medical staff membership, including enforcement relating to voluntary remediation, disciplinary, and corrective action, including revocation and termination of membership and privileges.

8. The mechanism for fair-hearing and appeal procedures.

9. The modification of medical policy, procedures, and programs.

10. Overseeing clinical care rendered by residents and licensed independent practitioners.

11. Reviewing and amending, when indicated, medical staff *Bylaws, Rules and Regulations*.

1. Promoting medical ethics and patient rights.

13. Overseeing the performance of clinical services including quality, safety, outcomes, efficiency and assessment of needs.

C. Meetings

The Medical Staff Executive Committee shall meet as often as necessary in order to fully discharge its duties and responsibilities in a timely, efficient manner. Minutes of the Medical Staff Executive Committee shall be forwarded to the University Hospital Committee . Those members attending and capable of voting shall constitute quorum. At times appropriate and necessary, the Medical Staff Executive Committee may take action without a meeting by unanimous consent in writing (setting forth the action so taken), signed by each member entitled to vote thereat.

ARTICLE XV

Director of Medical Affairs

SECTION 1. Qualifications and Selection

The Director of Medical Affairs shall be a member of the active medical staff. Appointment will be made by the Chief Medical Officer upon recommendation of the Associate Vice President for Medical Center Operations.

SECTION 2. Term of Office, Evaluation and Removal

A. The Director of Medical Affairs term of office shall be determined by the Chief Medical Officer. Any officer of the Medical Staff may be removed from office for valid cause, including, but not limited to, gross neglect or misfeasance in office, or serious acts of moral turpitude.

B. The Chief Medical Officer and Associate Vice President for Medical Center Operations, shall periodically review and evaluate the duties, activities, performance, accomplishments, and appointment of the Director of Medical Affairs. Such review shall be completed at least annually.

SECTION 3. Vacancies in Office

A. In the event the Director of Medical Affairs should be temporarily unable to fulfill the duties of the office, the duties shall be assumed by the Chief Medical Officer or their designee.

B. In the event the position becomes permanently vacant, the Chief Medical Officer may appoint a new Director of Medical Affairs as described in Article XV section 1.

SECTION 4. Duties of the Director of Medical Affairs

The Director of Medical Affairs will execute the responsibilities of the Chief Medical Office in a delegated manner. These duties include overseeing the creation and operation of processes relevant to the medical staff, including, but are not limited to:

A. acting in coordination and cooperation with the Associate Vice President for Medical Center Operations, and President of the Medical Staff in all matters of mutual concern within the Hospital which includes assuring compliance with the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards, and with state and federal regulatory requirements;

B. With the President of the Medical Staff serves as liaison between Medical Staff, Hospital Administration, and the University Hospital Committee

C. Is ex officio member (without vote) of all standing Medical Staff committees

D. in cooperation with the office of the Associate Vice President for Medical Center Operations, maintaining accurate up-to-date files on all staff members, which shall include all application and reapplication forms, recommendations, evaluations, and any other information pertinent to the medical staff members functions and membership status;

E. requesting from National Practitioner Data Bank and state licensure boards information regarding medical or dental and related health professions practitioners at the time of application for medical staff or clinical privileges; and biannually at the time of reappointment thereafter, and bringing information so obtained to the attention of the Medical Staff Executive Committee at the time of appointment or reappointment;

F. reporting to National Data Bank, state licensure board, and other organizations as required by law (1) restriction, reduction, cancellation, or non-renewal of privileges for quality care reasons; and (2) malpractice settlements or judgments;

G. having oversight responsibility for the application and enforcement of *Medical Staff Bylaw*s and *Rules and Regulation*s, for the implementation of corrective action where indicated, and for the medical staff's compliance with procedural safeguards in all instances where corrective action has been requested against a practitioner;

H. having oversight responsibility for assuring ethical conduct and acceptable professional behavior of members of the medical staff, and enforcing bylaws, rules, regulations, policies, and procedures including adherence to Hospital policies, *Behavioral Standards in Patient Care*, and the Medical Center's Corporate Compliance Program as applicable to practitioners;

G. oversees undergraduate and graduate medical education clinical activities;

H. provides a liaison role with community voluntary clinical faculty, and

I. delegating duties and activities as deemed necessary and appropriate.

ARTICLE XVI

MEDICAL STAFF MEETINGS

SECTION 1. Special Meetings

A. The Dean or Chief Medical Officer, or President of the Medical Staff may call a special meeting of the medical staff at any time. The Dean or President of the Medical Staff shall call a special meeting within thirty days after receipt of a written request for same, signed by not less than one-fourth of the active staff and stating the purpose of such meeting. The President of the Medical Staff shall designate the time and place of any special meeting.

B. Written or printed notice stating the purpose, place, day, and hour of any special meeting of the active medical staff shall be delivered, either personally or by mail, to each member of the active staff not less than seven (7) nor more than thirty (30) days before the date of such meeting, by or at the direction of the President of the Medical Staff (or other persons authorized to call the meeting).

SECTION 2. Quorum

The presence of 50% those members in good standing, present and attending, and capable of voting shall constitute a quorum for all other actions. If an appropriate quorum is not present, the Medical Staff Executive Committee shall, at its next meeting, act for the staff on all issues requiring vote.

SECTION 3. Parliamentary Authority

All meetings of the medical staff shall be conducted according to *Robert's Rules of Order, Revised*, except in cases where such rules are inconsistent with these *Bylaw*s.

SECTION 4. Manner of Action

The action of a majority of the members present at a meeting at which a quorum is present shall be the action of the committee. .

SECTION 5. Minutes

Minutes of each special medical staff meeting shall be prepared and include a record of the attendance of members and the vote taken on each matter. The minutes shall also show whether any member recused themselves from voting on any matter or participating in any discussion in which that member may have a conflict or duality of interest. The minutes shall be signed by the Dean, and copies thereof shall be promptly submitted to the President of the Medical Staff, and thereafter made available to all medical staff members, and be published on the web.

ARTICLE XVII

CONFIDENTIALITY AND IMMUNITY FROM LIABILITY

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

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

Second, that such privilege shall extend to members of the Hospital's medical staff and of its governing body, its other practitioners, its executive officers and representatives, and to third parties, who supply information to any of the foregoing authorized to receive, release, or act upon the same. For the purpose of this Article, the term "third parties" means both individuals and organizations from whom information has been requested by an authorized representative of the governing body or of the medical staff.

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

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

- applications for appointment or clinical privileges,
- periodic reappraisals for reappointment or clinical privileges,
- corrective action, including summary suspension,
- hearing and appellate reviews,
- medical care evaluations,
- utilization and PRO reviews,
- other Hospital, departmental, service, or committee activities related to quality patient care and inter-professional conduct.

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

Sixth, that in furtherance of the foregoing, each practitioner shall upon request of the Hospital execute releases in accordance with the tenor and import of this Article in favor of the individuals and organizations specified in paragraph "second," subject to the requirements of good faith and absence of malice.

Seventh, that the consents, authorizations, releases, rights, privileges, and immunities provided by these *Bylaws* for the protection of this Hospital's practitioners, other appropriate Hospital officials and personnel, and third parties, in connection with applications for initial appointment, shall also be fully applicable to the activities and procedures covered by this Article.

ARTICLE XVIII

REVIEW AND PUBLICATION OF *BYLAWS* *AND RULES AND REGULATIONS*

The *Bylaws* and *Rules and Regulations* of the Medical Staff of the University of Kentucky Hospital will be reviewed regularly by the Medical Staff Executive Committee, which will make recommendations for necessary changes in accordance with Articles XX and XXI of these *Bylaws*. If changes are made, such changes will be

published on the web as approved by the University Hospital Committee, and made available to all medical staff and license independent practitioners.

ARTICLE XIX

RULES AND REGULATIONS

The medical staff shall adopt such rules and regulations as may be necessary to implement more specifically the general principles found within these *Bylaws*, subject to the approval of the University Hospital Committee. These shall relate to the proper conduct of medical staff organizational activities as well as embody the level of practice that is to be required of each practitioner in the Hospital. Such rules and regulations shall be a part of these *Bylaws*, except that they may be amended or repealed at any regular meeting of the Medical Staff Executive Committee at which a quorum is present and without previous notice or at any special meeting on notice by a two-thirds vote of those present of the active medical staff. Such changes shall become effective when approved by the University Hospital Committee.

If there is a conflict between the *Medical Staff Bylaws* and the *Rules and Regulations*, the *Medical Staff Bylaws* shall prevail.

ARTICLE XX

AMENDMENTS

Neither the Medical Staff Executive Committee, acting on behalf of the medical staff, nor the University Hospital Committee may unilaterally amend the *Bylaws*. These *Bylaws* may be amended after submission of the proposed amendment at any regular or special meeting of the Medical Staff Executive Committee. A proposed amendment shall be referred to a special committee, which shall report on it at the next regular meeting of the Medical Staff Executive Committee or at a special meeting called for such purpose. To be adopted, an amendment shall require a two-thirds vote of total Medical Staff Executive Committee members. Amendments so made shall be effective when approved by the University Hospital Committee, which has final legal authority, may be subject to the approval of the University of Kentucky Board of Trustees.

Notwithstanding, nothing shall be deemed to limit the authority of the University Hospital Committee and Board of Trustees of the University, including the authority under the laws of the Commonwealth of Kentucky to amend these *Bylaws* in order to comply with applicable law, including the Conditions of Participation for Medicare; in order to comply with accreditation requirements; and in order to avoid liability exposure for the Hospital and its medical staff.

Members of the medical staff shall be provided with copies of all material amendments to these *Bylaws* or will have access to these *Bylaws*, including amendments, on the website.

ARTICLE XXI

ADOPTION

These *Bylaws* shall be adopted at any regular or special meeting of the Medical Staff Executive Committee shall replace any previous Bylaws, and shall be come effective when approved by the University Hospital Committee and may be subject to the approval of the Board of Trustees.

Approved by the Hospital Medical Staff Executive Committee: April 25, 2000

Approved by the Hospital Board of Directors (nka University Hospital Committee): May 2, 2000

Approved by the University Board of Trustees: June 19, 2001

Revised: November 28, 2000

Reviewed and Revised by Hospital Medical Staff Executive Committee: , 2005

Reviewed and Revised by the University Hospital Committee: , 2005

Reviewed and Revised by the University Board of Trustees: ,2005

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