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Principles of Medical Ethics, June 2001

Preamble

The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsibility to patients first and foremost, as well as to society, to other health professionals, and to self. The following Principles adopted by the American Medical Association are not laws, but standards of conduct, which define the essentials of honorable behavior for the physician.

Principles of Medical Ethics

I. A physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights.

II. A physician shall uphold the standards of professionalism, be honest in all professional interactions, and strive to report physicians deficient in character or competence, or engaging in fraud or deception, to appropriate entities.

III. A physician shall respect the law and also recognize a responsibility to seek changes in those requirements, which are contrary to the best interests of the patient.

IV. A physician shall respect the rights of patients, colleagues, and other health professionals, and shall safeguard patient confidences and privacy within the constraints of the law.

V. A physician shall continue to study, apply, and advance scientific knowledge, maintain a commitment to medical education, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.

VI. A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical care.

VII. A physician shall recognize a responsibility to participate in activities contributing to the improvement of the community and the betterment of public health.

VIII. A physician shall, while caring for a patient, regard responsibility to the patient as paramount.

IX. A physician shall support access to medical care for all people.

Adopted by the AMA’s House of Delegates, June 17, 2001
Renown South Meadows Medical Center Medical Staff Bylaws

The most recent amendments to these Bylaws were approved at the November 2014, meeting of the Board of Governors of Renown South Meadows Medical Center.

Article I: Definitions

“Acronyms” (Used in these Bylaws):

AACPM: American Association of Colleges of Podiatric Medicine
AAAHC: Accreditation Association for Ambulatory Health Care
ABMS: American Board of Medical Specialties
ABPS: American Board of Podiatric Surgery
ACGME: Accreditation Council for Graduate Medical Education
ACLS: Advanced Cardiac Life Support
ADA: American Dental Association
ADA: American Disabilities Act
AEGD: Advanced Education in General Dentistry
AHP: Allied Health Professional
AMA: American Medical Association
AOA: American Osteopathic Association
APP: Advanced Practice Professional
ASA: American Society of Anesthesiologists
ATLS: Advanced Trauma Life Support
C&P: Credentials and Privileges Committee
CME: Continuing Medical Education
CMO: Chief Medical Officer
COO: Chief Operating Officer
COS: Chief of Staff
DEA: Drug Enforcement Agency
EEG: Electroencephalogram
EGD: Esophagogastroduodenoscopy
ERCP: Endoscopic retrograde cholangiopancreatography
ER: Emergency Room
FDA: Federal Drug Administration
FPPE: Focused Professional Practice Evaluation
GPR: General Practice Residency
GYN: Gynecology
HEICS: Hospital Emergency Incident Command System
HIMS: Health Information Management Services
ICN: Intensive Care Nursery
ICU: Intensive Care Unit
ID: Identification
LIP: Licensed Independent Practitioner
MEC: Medical Executive Committee
NPO: medical instruction meaning to withhold oral food and fluids from a patient for various reasons.
NSMBE: Nevada State Medical Board Examiners
OB/GYN: Obstetrics & Gynecology
OB: Obstetrics
OIG: Office of the Inspector General
OPPE: Ongoing Professional Practice Evaluation
OR: Operating Room
PICU: Pediatric Intensive Care Unit
PPEC: Professional Practice Evaluation Committee (PPEC)
QA: Quality Assurance
RRMC: Renown Regional Medical Center
RSMMC: Renown South Meadows Medical Center

“Advanced Practice Professionals (APP’s)” means non-physician licensed practitioner employed by Members of the Medical Staff or Hospital or by contract to the Hospital. Currently defined as: Advanced Nurse Practitioners, Physician Assistant, Nurse Midwife and Nurse Anesthetist.

“Allied Health Professionals (AHP’s)” means all non-physician practitioners employed by Members of the Medical Staff or Hospital or by contract to the Hospital. Currently defined as: Psychologist, Neuropsychologist, Perfusionist, Genetics Counselor, Surgical First Assistant (includes dental), Life Skill provider and Pathology Assistant.

“Applicant” means an individual who is in the process of applying for Membership and/or clinical privileges.

“Appointee” or “Member” means an individual who has completed the application process and has been appointed to the Medical Staff.

“Board of Governors” means the Board of Governors of Renown South Meadows Medical Center, a Nevada nonprofit corporation.

“Board Certified” means possessing current certification from a specialty Board recognized by the American Board of Medical Specialties (ABMS) or the American Osteopathic Association (AOA).

“Chief Executive Officer” (CEO)” means the CEO and/or Administrator of Renown South Meadows Medical Center and Renown Rehabilitation Hospital, and his or her designees, collectively.

“Chief Medical Officer (CMO)” means the CMO of Renown Health who is the Administrative Liaison to the Medical Staff.

“Hospital,” unless otherwise expressly stated in these Bylaws, collectively means Renown South Meadows Medical Center, a licensed acute care hospital, and Renown Rehabilitation Hospital, a licensed rehabilitation hospital, both of which are located in Reno, Nevada, and are owned and operated by Renown South Meadows Medical Center, a Nevada nonprofit corporation.
“Medical Executive Committee” means the Medical Executive Committee of the Medical Staff. When appropriate, the Medical Executive Committee may delegate functions to other Medical Staff committees, and specific reference to the Medical Executive Committee shall not prevent such delegation.

“Medical Staff” means all licensed physicians, Medicine or Osteopathy, podiatrists, dentists, oral and maxillofacial surgeons who are privileged to attend patients in the Hospital.

“Medical Staff Services” is a Delegated Agreement with Renown Regional Medical Center to discharge all Medical Staff responsibilities and functions on behalf of the Chief of Staff and Hospital CEO, and serve as a resource for the entire Medical Staff and to support the Committees, Departments, Sections and Officers of the Medical Staff.

“Physician” means a doctor of medicine, osteopathy, dentistry, oral and maxillofacial surgery and podiatry legally authorized to practice medicine and surgery by the State of Nevada. S/he performs such function or action within the scope of his/her license.

“Policies,” when used in context, means those associated Policies and Procedures established by the Medical Executive Committee and approved by the Board of Governors.

“Rules,” when used in context, means those associated Rules and Regulations established by the Medical Executive Committee and approved by the Board of Governors.

“Special Notice” means hand delivery, certified mail (return receipt requested), or overnight delivery service providing receipt.
RULE 2-1 Initial Application for Membership and Appointment to the Medical Staff

All credentialing for South Meadows is performed by the Renown Health System Medical Staff Services Department currently located at the main campus “Renown Regional Medical Center”. This allows for the sharing of credentialing information and for both facilities to rely on the information provided by Renown Health System, Medical Staff Services Department. South Meadows and the Rehabilitation Hospital are responsible for approving and granting privileges for their facilities with the information provided by the Renown Health System Medical Staff Services Department.
Section 1. Medical Staff Purpose and Authority

1.1 Purpose
The purpose of this medical staff is to organize the activities of physicians and other clinical practitioners who practice at Renown South Meadows Medical Center in order to carry out, in conformity with these bylaws, the functions delegated to the medical staff by the hospital Board of Governors.

1.2 Authority
Subject to the authority and approval of the Board of Governors the medical staff will exercise such power as is reasonably necessary to discharge its responsibilities under these bylaws and associated rules, regulations, and policies and under the corporate bylaws of the Renown South Meadows Medical Center. Henceforth, whenever the term “the hospital” is used, it shall mean Renown South Meadows Medical Center; and whenever the term “the Board” is used, it shall mean Board of Governors. Whenever the term “CEO” is used, it shall mean the Chief Executive Officer appointed by the Board to act on its behalf in the overall management of the hospital. The term CEO includes a duly appointed acting administrator serving when the CEO is away from the hospital.
Section 2. Qualifications for Membership and/or Privileges

2.1 Nature of Medical Staff Membership

Membership on the medical staff of the hospital is a privilege that shall be extended only to professionally competent physicians (M.D. or D.O.), dentists, oral and maxillofacial surgeons, and podiatrists who continuously meet the qualifications, standards, and requirements set forth in these bylaws and associated rules, regulations, policies, and procedures of the medical staff and the hospital.

2.2 Qualifications for Membership

No practitioner shall be entitled to membership on the medical staff or to privileges merely by virtue of licensure, membership in any professional organization, or privileges at any other healthcare organization.

The following qualifications must be met and continuously maintained by all applicants for medical staff appointment, reappointment, or clinical privileges:

2.2.1 Demonstrate that s/he has successfully graduated from an approved school of medicine, osteopathy, dentistry, podiatry, clinical psychology, or applicable recognized course of training in a clinical profession eligible to hold privileges;

2.2.2 Have a current unrestricted state or federal license as a practitioner, applicable to his or her profession, and providing permission to practice within the state of Nevada;

2.2.3 Have a record that is free from current Medicare/Medicaid sanctions and not be on the OIG List of Excluded Individuals/Entities;

2.2.4 Have a record that shows the applicant has never been convicted of, or entered a plea of guilty or no contest to, any felony relating to controlled substances, illegal drugs, insurance or healthcare fraud or abuse, violence, or abuse (physical, sexual, child, or elder) in any jurisdiction;

2.2.5 A physician applicant, MD, or DO, must have successfully completed an allopathic or osteopathic residency program, approved by the Accreditation Council for Graduate Medical Education (ACGME) or the American Osteopathic Association (AOA) and be currently board certified or become board certified within seven (7) years of completing formal training as defined by the appropriate specialty board of the American Board of Medical Specialties, the American Osteopathic Association, or the National Board of Physicians and Surgeons (NBPAS);

2.2.6 Dentists must have graduated from an American Dental Association approved school of dentistry accredited by the Commission of Dental Accreditation;

2.2.7 Oral and maxillofacial surgeons must have graduated from an American Dental Association approved school of dentistry accredited by the Commission of Dental Accreditation and successfully completed an American Dental Association approved residency program and be board certified or become board certified within seven (7) years of completing formal training as defined by the American Board of Oral and Maxillofacial Surgery;
2.2.8 A podiatric physician, DPM, must have successfully completed a two-year (2) residency program in surgical, orthopedic, or podiatric medicine approved by the Council on Podiatric Medical Education of the American Podiatric Medical Association (APMA), and be board certified or become board certified within seven (7) years of completing formal training as determined by the American Board of Podiatric Surgery or the American Board of Podiatric Orthopedics and Primary Podiatric Medicine;

2.2.9 A psychologist must have an earned a doctorate degree, (PhD or Psy.D, in psychology) from an educational institution accredited by the American Psychological Association and have completed at least two (2) years of clinical experience in an organized healthcare setting, supervised by a licensed psychologist, one (1) year of which must have been post doctorate, and have completed an internship endorsed by the American Psychological Association (APA), and be board certified as appropriate to the area of clinical practice;

2.2.10 Have appropriate written and verbal communication skills;

2.2.11 Have appropriate personal qualifications, including applicant’s consistent observance of ethical and professional standards including compliance with the Renown Code of Ethics. These standards include, at a minimum:
   a. Abstinence from any participation in fee splitting or other illegal payment, receipt, or remuneration with respect to referral or patient service opportunities; and
   b. A history of consistently acting in a professional, appropriate, and collegial manner with others in previous clinical and professional settings.

2.3 In addition to privilege-specific criteria, the following qualifications must also be met and maintained by all applicants requesting clinical privileges:

2.3.1 Demonstrate his/her background, experience, training, current competence, knowledge, judgment, and ability to perform all privileges requested;

2.3.2 Possess a current, valid, unrestricted drug enforcement administration (DEA) or Nevada Board of Pharmacy Controlled Substance Registration (CSR) number, if applicable;

2.3.3 Possess a valid NPI number;

2.3.4 Upon request provide evidence of both physical and mental health that does not impair the fulfillment of his/her responsibilities of medical staff membership and/or the specific privileges requested by and granted to the applicant;

2.3.5 Any practitioner granted privileges who may have occasion to admit an inpatient must demonstrate the capability to provide continuous and timely care to the satisfaction of the MEC and Board;

2.3.6 Demonstrate recent clinical performance within the last twenty-four (24) months with an active clinical practice in the area in which clinical privileges are sought adequate to meet current clinical competence criteria;

2.3.7 The applicant is requesting privileges for a service the Board has determined appropriate for performance at the hospital. There must also be a need for this service under any Board approved medical staff development plan;
2.3.8 Provide evidence of professional liability insurance appropriate to all privileges requested and of a type and in an amount established by the Board after consultation with the MEC.

2.4 Exceptions

2.4.1 All practitioners who are current medical staff members and/or hold privileges as of January 1, 2006 and who have met prior qualifications for membership and/or privileges shall be exempt from board certification requirements.

2.4.2 Only the Board may create additional exceptions, but only after consultation with the MEC and if there is documented evidence that a practitioner demonstrates an equivalent competence in the areas of the requested privileges.

2.5 Disaster Privileges

A disaster is an emergency that, due to its complexity, scope, or duration, threatens the organization’s capabilities and requires outside assistance to sustain patient care, safety, or security functions.

2.5.1 If the institution’s Disaster Plan has been activated and the organization is unable to meet immediate patient needs, the CEO and other individuals as identified in the institution’s Disaster Plan with similar authority, may, on a case by case basis, consistent with medical licensing and other relevant state statutes, grant disaster privileges to selected Licensed Independent Practitioners.

2.5.2 These practitioners must present a valid government-issued photo identification issued by a state or federal agency (e.g., driver’s license or passport) and at least one of the following:

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

b. A current license to practice;

c. Primary source verification of the license;

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

e. Identification indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances (such authority having been granted by a federal, state, or municipal entity); or

f. Identification by a current hospital or medical staff member(s) who possesses personal knowledge regarding the volunteer’s ability to act as a licensed independent practitioner during a disaster.

2.5.3 The medical staff has a mechanism (i.e., badging) to readily identify volunteer practitioners who have been granted disaster privileges.

2.5.4 The medical staff oversees the professional performance of volunteer practitioners who have been granted disaster privileges by direct observation, mentoring, or clinical record review. The organization makes a decision, (based on information obtained regarding the professional practice of the volunteer), within 72 hours whether disaster recovery privileges should be continued.
2.5.5 Primary source verification of licensure begins as soon as the immediate situation is under control, and is completed within 72 hours from the time the volunteer practitioner presents to the organization. If primary source verification cannot be completed in 72 hours, there is documentation of the following: 1) why primary source verification could not be performed in 72 hours; 2) evidence of a demonstrated ability to continue to provide adequate care, treatment, and services; and 3) an attempt to rectify the situation as soon as possible.

2.5.6 Primary Source Verification of licensure is not required if the volunteer licensed independent practitioner has not provided care, treatment or services under the disaster privileges.

2.5.7 Once the immediate situation has passed and such determination has been made consistent with the institution’s Disaster Plan, the practitioner’s disaster privileges will terminate immediately.

2.5.8 Any individual identified in the institution’s Disaster Plan with the authority to grant disaster privileges shall also have the authority to terminate disaster privileges. Such authority may be exercised in the sole discretion of the hospital and will not give rise to a right to a fair hearing or an appeal.

2.6 **Nondiscrimination**

The hospital will not discriminate in granting staff appointment and/or clinical privileges on the basis of national origin, race, gender, religion, disability unrelated to the provision of patient care or required medical staff responsibilities, or any other basis prohibited by applicable law, to the extent the applicant is otherwise qualified.

2.7 **Conditions and Duration of Appointment**

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

2.8 **Medical Staff Members Responsibilities**

2.7.1 Each staff member must provide for appropriate, timely, and continuous care of his/her patients at the level of quality and efficiency generally recognized as appropriate by medical professionals in the same or similar circumstances.

2.7.2 Each staff member and practitioner with privileges must participate, as assigned or requested, in quality/performance improvement/peer review activities and in the discharge of other medical staff functions (including service on appropriate medical staff committees) as may be required.

2.7.3 Each staff member, consistent with his/her granted clinical privileges, must participate in the on call coverage of the emergency department or in other hospital coverage programs as determined by the MEC and the Board and documented in the rules and regulations, after receiving input from the appropriate clinical specialty, to assist in meeting the patient care needs of the community.
2.7.4 Each staff member and practitioner with privileges must submit to any pertinent type of health evaluation as requested by the officers of the medical staff, Chief Executive Officer (CEO), and/or Department Chair when it appears necessary to protect the well-being of patients and/or staff, or when requested by the MEC or Credentials & Privileges Committee as part of an evaluation of the member’s or practitioner’s ability to exercise privileges safely and competently, or as part of a post-treatment monitoring plan consistent with the provisions of any medical staff and hospital policies addressing physician health or impairment.

2.7.5 Each staff member and practitioner with privileges must abide by the medical staff bylaws and any other rules, regulations, policies, procedures, AMA Code of Conduct, and standards of the medical staff and hospital.

2.7.6 Each staff member and practitioner with privileges must provide evidence of professional liability coverage of a type and in an amount sufficient to cover the clinical privileges granted or an amount established by the Board, whichever is higher. In addition, staff members shall comply with any financial responsibility requirements that apply under state law to the practice of their profession. Each staff member and practitioner with privileges shall notify the Chief of Staff (COS) or designee immediately of any and all malpractice claims filed in any court of law against the medical staff member.

2.7.7 Each applicant for privileges or staff member or practitioner with privileges agrees to release from any liability, to the fullest extent permitted by law, all persons for their conduct in connection with investigating and/or evaluating the quality of care or professional conduct provided by the medical staff member and his/ her credentials.

2.7.8 Each staff member and practitioner with privileges shall prepare and complete in timely fashion, according to medical staff and hospital policies, the medical and other required records for all patients to whom the practitioner provides care in the hospital, or within its facilities, clinical services, or departments.

a. A medical history and physical examination shall be completed no more than thirty (30) days before or twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The medical history and physical examination must be completed and documented by a physician, an oral and maxillofacial surgeon, dentist, podiatrist, or other qualified licensed individual in accordance with State law and hospital policy.

b. An updated examination of the patient, including any changes in the patient’s condition, shall be completed and documented within twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services, when the medical history and physical examination is completed within thirty (30) days before admission or registration. The updated examination of the patient, including any changes in the patient’s condition, must be completed and documented by a physician, an oral and maxillofacial surgeon, dentist, podiatrist, or other qualified licensed individual in accordance with State law and hospital policy.
c. **Complete History and Physical Examination**

For patients admitted to the hospital or who will be undergoing an outpatient procedure using anesthesia services, a complete history and physical (“H&P”) must be done. The complete H&P should include:

I. Chief complaint or reason for the admission or procedure;

II. A description of the present illness;

III. Past medical history, including past and present diagnoses, illnesses, operations, injuries, treatment, allergies, and health risk factors;

IV. An age-appropriate social history;

V. A pertinent family history;

VI. A review of systems;

VII. Thorough and relevant physical findings including vital signs, heart exam, lung exam, and exam of the pertinent body area; and

VIII. Documentation of medical decision-making including a review of diagnostic test results; response to prior treatment; assessment, clinical impression or diagnosis; plan of care; evidence of medical necessity and appropriateness of diagnostic and/or therapeutic services; counseling provided, and coordination of care.

c. **Focused History and Physical Examination**

For patients undergoing an outpatient procedure under moderate sedation, a focused history and physical may be done in place of a complete H&P. This focused H&P should include:

I. Chief complaint;

II. History of the present illness including any prior treatment(s) performed;

III. Past medical history including allergies and current medications;

IV. Physical examination including vital signs, heart exam, lung exam, and exam of the pertinent body area;

V. Pertinent laboratory or radiologic testing results

VI. Assessment; and

VII. Plan of care.
2.7.9 Each staff member and practitioner with privileges will use confidential information only as necessary for treatment, payment, or healthcare operations in accordance with HIPAA laws and regulations, to conduct authorized research activities, or to perform medical staff responsibilities. For purposes of these bylaws, confidential information means patient information, peer review information, and the hospital's business information designated as confidential by the hospital or its representatives prior to disclosure.

2.7.10 Each staff member and practitioner with privileges must participate in any type of competency evaluation when determined necessary by the MEC and/or Board in order to properly delineate that member’s clinical privileges.

2.7.11 Each medical staff leader shall disclose to the medical staff any ownership or financial interest that may conflict with, or have the appearance of conflicting with, the interests of the medical staff or hospital. Medical staff leadership will deal with conflict of interest issues per the Medical Staff Conflict of Interest policy.

2.7.12 Each applicant for privileges and each privileged practitioner acknowledges and agrees that credentialing, peer review and quality assurance/performance improvement (“QA/PI”) data and information (collectively “Information”) may or shall be shared with, considered and used by other Renown Health hospitals for credentialing, peer review and QA/PI activities.

2.8 Medical Staff Member Rights

2.8.1 Each staff member in the Active category has the right to a meeting with the MEC on matters relevant to the responsibilities of the MEC that may affect patient care or safety. In the event such practitioner is unable to resolve a matter of concern after working with his/her Department Chair or other appropriate medical staff leader(s), that practitioner may, upon written notice to the Chief of Staff two (2) weeks in advance of a regular meeting, meet with the MEC to discuss the issue.

2.8.2 Each staff member in the Active category has the right to initiate a recall election of a medical staff officer by following the procedure outlined in Section 4.7 of these bylaws, regarding removal and resignation from office.

2.8.3 Each staff member in the Active category may initiate a call for a general staff meeting to discuss a matter relevant to the medical staff by presenting a petition signed by ten percent (10%) of the members of the Active category. Upon presentation of such a petition, the MEC shall schedule a general staff meeting for the specific purposes addressed by the petitioners. No business other than that detailed in the petition may be transacted.

2.8.4 Each staff member in the Active category may challenge any rule, regulation, or policy established by the MEC. In the event that a rule, regulation, or policy is thought to be inappropriate, any medical staff member may submit a petition signed by ten percent (10%) of the members of the Active category. Upon presentation of such a petition, the adoption procedure outlined in Section 9.3 will be followed.
2.8.5 Each staff member in the Active category may call for a Department meeting by presenting a petition signed by ten percent (10%), but in no case less than two (2), of the members of the Department. Upon presentation of such a petition the Department Chief will schedule a Department meeting.

2.8.6 The above sections 2.7.1 to 2.7.5 do not pertain to issues involving individual peer review, formal investigations of professional performance or conduct, denial of requests for appointment or clinical privileges, or any other matter relating to individual membership or privileges. Investigations, Corrective Action, Hearing and Appeal Plan provides recourse in these matters.

2.8.7 Any practitioner eligible for medical staff appointment has a right to a hearing/appeal pursuant to the conditions and procedures described in the medical staff’s hearing and appeal plan.

2.9 Staff Dues

Annual medical staff dues, if any, shall be determined by the MEC. Failure of a medical staff member to pay dues shall be considered a voluntary resignation from the medical staff. The MEC may pass policies from time to time which exempt from dues payment certain categories of membership or members holding specified leadership positions.

2.10 Indemnification

2.10.1 Members of the medical staff are entitled to the applicable immunity provisions of state and federal law for the credentialing, peer review and performance improvement work they perform on behalf of the hospital and medical staff.

2.10.2 Subject to applicable law, the hospital shall indemnify against reasonable and necessary expenses, costs, and liabilities incurred by a medical staff member in connection with the defense of any pending or threatened action, suit, or proceeding to which he is made a party by reason of his having acted in an official capacity in good faith on behalf of the hospital or medical staff. However, no member shall be entitled to such indemnification if the acts giving rise to the liability constituted willful misconduct, breach of a fiduciary duty, self-dealing or d\ faith.
Section 3. Categories of the Medical Staff

3.1 The Active (Voting) Category

3.1.1 Qualifications

Members of this category must have served on the medical staff for at least one year and:

a. Comply with the specifications of their assigned Specialty Delineation of Privileges (DoP).

and

b. Have attended at least fifty percent (50%) of the meetings in the department the practitioner is assigned to.

In the case of a new appointee to the medical staff, the practitioner must have met the meeting attendance requirement and any proctoring/mentoring requirements specified under their Specialty Delineation of Privileges to move from Affiliate status to Active status.

In the event that a member of the Active category does not meet the qualifications for reappointment to the Active category, and if the member is otherwise abiding by all bylaws, rules, regulations, and policies of the medical staff and hospital, the member may be appointed to another medical staff category if s/he meets the eligibility requirements for such category.

3.1.2 Prerogatives

Members of this category may:

a. Attend medical staff, Department, and Section meetings of which s/he is a member and any medical staff or hospital education programs;

b. Vote on all matters presented by the medical staff, Department, Section, and committee(s) to which the member is assigned; and

c. Hold office and sit on or be the chair of any committee in accordance with any qualifying criteria set forth elsewhere in the medical staff bylaws or medical staff policies.

3.1.3 Responsibilities

Members of this category shall:

a. Contribute to the organizational and administrative affairs of the medical staff;

b. Actively participate as requested or required in activities and functions of the medical staff, including quality/performance improvement and peer review, credentialing, risk, and utilization management, medical records completion and in the discharge of other staff functions as may be required; and

c. Fulfill or comply with any applicable medical staff or hospital policies or procedures.
3.2 The Affiliate Category

3.2.1 Qualifications
The affiliate category is reserved for medical staff members who do not meet the eligibility requirements for the Active category.

3.2.2 Prerogatives
Members of this category may:
   a. Attend medical staff, department, and section meetings of which s/he is a member and any medical staff or hospital education programs;
   b. Not vote on matters presented by the entire medical staff or department or be an officer of the medical staff; and
   c. Serve on medical staff committees, other than the MEC, and may vote on matters that come before such committees.

3.2.3 Responsibilities
Members of this category shall have the same responsibilities as Active category members.

3.3 Courtesy Staff

3.3.1 Qualifications
The Courtesy category is for those practitioners who wish to build or maintain strategic relationship between the hospital and practitioners who do not practice within the hospital.

3.1.2 Prerogatives
Members of this category may:
   a. Attend medical staff, department, and section meetings of which he/she is a member and any medical staff or hospital education programs.
   b. Visit patients in the hospital
   c. Review medical records for patients referred for admission/services and write a non-codeable Courtesy Note as desired.

3.1.3 Limitations
Physicians appointed to this category may not:
   a. Admit or discharge patients to the Hospital.
   b. Assist in surgery.
   c. Write orders.
   d. Hold Office or Vote as a Member of the Medical Staff.

3.1.4 Responsibilities
   a. Fulfill or comply with any applicable medical staff or hospital policies or
procedures.

3.4 Telemedicine Category

3.4.1 Qualifications
The Telemedicine Category is reserved for medical staff members who provide telemedicine services to patients outside of the hospital. Credentialing will be done by the Hospital or by Proxy from the home facility/contracting agency.

3.4.2 Prerogatives
They may attend medical staff, department, and section meetings and continuing medical education activities.

3.4.3 Responsibilities
Fulfill and comply with any applicable medical staff or hospital policies or procedures.

3.5 Honorary Category
The Honorary Category is restricted to those individuals recommended by the MEC and approved by the Board. Appointment to this category is entirely discretionary and may be rescinded at any time. Members of the Honorary Category shall consist of those members who have retired from active hospital practice, who are of outstanding reputation, and have provided distinguished service to the hospital. They may attend medical staff, department, and section meetings, continuing medical education activities, and may be appointed to committees. They shall not hold clinical privileges, hold office or be eligible to vote.
Section 4. Officers of the Medical Staff and MEC at-large members

4.1 Officers of the Medical Staff and MEC at-large members

4.1.1 Chief of Staff

4.1.2 Vice Chief of Staff

4.1.3 Secretary

4.2 Qualifications of Officers and MEC at-large members

4.2.1 Officers must be members in good standing of the Active category for at least five (5) years and be actively involved in patient care in the hospital, have previously served on the Medical Executive Committee for at least two (2) years, indicate a willingness and ability to serve, have no pending adverse recommendations concerning medical staff appointment or clinical privileges, have participated in medical staff leadership training and/or be willing to participate in such training during their term of office, and be in compliance with the professional conduct policies of the hospital. The medical staff nominating committee will have discretion to determine if a staff member wishing to run for office meets the qualifying criteria. There is automatic succession from the secretary to the Vice Chief of Staff, from the Vice Chief of Staff to the Chief of Staff, and from the Chief of Staff to the Immediate Past Chief of Staff.

4.2.2 MEC at-large members must be in good standing in the Active category, be in compliance with the professional conduct policies of the hospital and have participated in medical staff leadership training and/or be willing to participate in such training during their term.

4.2.3 Officers and MEC at-large members may not simultaneously hold a leadership position on another hospital's medical staff or in an unaffiliated facility. Noncompliance with this requirement will result in the officer being automatically removed from office.

4.3 Election of Officers and MEC at-large members

4.3.1 The Nominating committee shall offer at least one nominee for each available position (secretary or MEC At-Large Member). Nominations must be announced, and the names of the nominees distributed to all members of the Active medical staff at least 30 days prior to the election.

4.3.2 A petition signed by at least ten percent (10%) of the members of the Active staff may add nominations to the ballot. The medical staff must submit such a petition to the Chief of Staff at least fourteen (14) days prior to the election for the nominee(s) to be placed on the ballot. The Nominating committee must determine if the candidate meets the qualifications in section 4.2 above before he/she can be placed on the ballot.
4.3.3 Officers and MEC at-large members shall be elected prior to the expiration of the term of the current officers. Only members of the Active category shall be eligible to vote. The MEC will determine the mechanisms by which votes may be cast. The mechanisms that may be considered include written mail ballots and electronic voting via computer, fax, or other technology for transmitting the member’s voting choices. No proxy voting will be permissible. The nominee(s) who receives the greatest number of votes cast will be elected. In the event of a tie vote, the MEC will make arrangements for a repeat vote(s) deleting the candidate with the lowest number of votes until one candidate receives a greater number of votes.

4.4 Term of Office

All officers and MEC at-large members serve a term of two (2) years. They shall take office in the month of January. An individual serving as an officer may not be reelected for two successive terms since there is automatic succession from the secretary to the Vice Chief of Staff and from the Vice Chief of Staff to the Chief of Staff. Each officer shall serve in office until the end of his/her term of office or until a successor is appointed/elected or unless s/he resigns sooner or is removed from office.

4.5 Vacancies of Office

The MEC shall fill vacancies of office during the medical staff year, except the office of the Chief of Staff. If there is a vacancy in the office of the Chief of Staff, the Vice Chief of Staff shall serve the remainder of the unexpired term and then serve their own term as Chief of Staff.

4.6 Duties of Officers, Immediate Past Chief of Staff and MEC at-large members

4.6.1 Chief of Staff: The Chief of Staff is the primary elected officer of the medical staff and is the medical staff’s advocate and representative in its relationships to the Board and the administration of the hospital. The Chief of Staff, jointly with the MEC, provides direction to and oversees medical staff activities related to assessing and promoting continuous improvement in the quality of clinical services and all other functions of the medical staff as outlined in the medical staff bylaws, rules, regulations, and policies. Specific responsibilities and authority are to:

a. Call and preside at all general and special meetings of the medical staff;

b. Serve as chair of the MEC and as ex officio member of all other medical staff committees without vote, and to participate as invited by the CEO or the Board on hospital or Board committees;

c. Enforce medical staff bylaws, rules, regulations, and medical staff/hospital policies;

d. Except as stated otherwise, appoint committee chairs and all members of medical staff standing and ad hoc committees; in consultation with hospital administration, appoint medical staff members to appropriate hospital committees or to serve as medical staff advisors or liaisons to carry out specific functions; in consultation with the chair of the Board, appoint the medical staff members to appropriate Board committees when those are not designated by position or by specific direction of the Board or otherwise prohibited by state law;
e. Support and encourage medical staff leadership and participation on interdisciplinary clinical performance improvement activities;

f. Report to the Board the MEC’s recommendations concerning appointment, reappointment, delineation of clinical privileges or specified services, and corrective action with respect to practitioners who are applying for appointment or privileges, or who are granted privileges or providing services in the hospital;

g. Continuously evaluate and periodically report to the hospital, MEC, and the Board regarding the effectiveness of the credentialing and privileging processes;

h. Review and enforce compliance with standards of ethical conduct and professional demeanor among the practitioners on the medical staff in their relations with each other, the Board, hospital management, other professional and support staff, and the community the hospital serves;

i. Communicate and represent the opinions and concerns of the medical staff and its individual members on organizational and individual matters affecting hospital operations to hospital administration, the MEC, and the Board;

j. Attend Board meetings and Board committee meetings as invited by the Board;

k. Ensure that the decisions of the Board are communicated and carried out within the medical staff; and

l. Perform such other duties, and exercise such authority commensurate with the office as are set forth in the medical staff bylaws.

4.6.2 Vice Chief of Staff: In the absence of the Chief of Staff, the Vice Chief of Staff shall assume all the duties and have the authority of the Chief of Staff. The Vice Chief of Staff shall chair the Credentials & Privileges Committee. S/he shall perform such further duties to assist the Chief of Staff as the Chief of Staff may request from time to time.

4.6.3 Secretary: This officer shall serve on the Credentials & Privileges Committee and shall chair the Bylaws Committee. S/he shall perform such further duties to assist the Chief of Staff as the Chief of Staff may request from time to time.

4.6.4 Immediate Past Chief of Staff: This officer will serve as a consultant to the Chief of Staff and Vice Chief of Staff and provide feedback to the officers regarding their performance of assigned duties on an annual basis. S/he shall perform such further duties to assist the Chief of Staff as the Chief of Staff may request from time to time.

4.6.5 MEC at-large members: These members will advise and support the medical staff officers and are responsible for representing the needs/interests of the entire medical staff, not simply representing the preferences of their own clinical specialty.
4.7 Removal and Resignation from Office

4.7.1 **Removal by vote:** A medical staff officer or MEC At-Large Member may be removed for a violation of the bylaws or rules & regulations by either a:
   a. Majority vote of the Board of Governors,
   b. Vote of the Chief of Staff, or
   c. 2/3 supermajority vote of the Medical Executive Committee.

4.7.2 **Automatic removal:** Any officer or MEC at-large member shall be automatically removed for failure to meet those responsibilities assigned within these bylaws, failure to comply with policies and procedures of the medical staff, for conduct or statements that damage the hospital, its goals, or programs, or an automatic or precautionary (summary) suspension of clinical privileges.

4.7.3 **Resignation:** Any elected officer or MEC at-large member may resign at any time by giving written notice to the MEC. Such resignation takes effect on the date of receipt, when a successor is elected, or any later time specified therein.
Section 5. Medical Staff Organization

5.1 Organization of the Medical Staff

5.1.1 The medical staff shall be organized into departments. The medical staff may create clinical sections within a department in order to facilitate medical staff activities. A list of departments organized by the medical staff and formally recognized by the MEC is listed in the Rules & Regulations.

The MEC, with approval of the Board, may designate new medical staff departments or clinical sections or dissolve current departments or clinical sections as it determines will best promote the medical staff needs for promoting performance improvement, patient safety, and effective credentialing and privileging.

5.2 Qualifications, Selection, Term, and Removal of Department Chairs and Section Chiefs

5.2.1 Each Department Chair and Section Chief shall serve a term of two (2) years commencing on January 1, with half of the Department Chairs and Section Chiefs appointed each year. Department Chairs and Section Chiefs may be appointed to serve successive terms. All Chairs and Chiefs must be members of the Active medical staff have relevant clinical privileges and be certified by an appropriate specialty board or have affirmatively established comparable competence through the credentialing process. Department Chairs and Section Chiefs may not simultaneously hold a leadership position on another hospital’s medical staff or in an unaffiliated facility. Noncompliance with this requirement will result in the Chair/Chief being automatically removed from office.

5.2.2 Department Chairs and Section Chiefs shall be appointed by the Chief of Staff based upon a recommendation of the Department or Section. Each Department and Section shall establish procedures for identifying and electing candidates and these procedures must be ratified by the MEC. If the post of Chair of a Department is vacated, the Chief of Staff shall appoint a new who will preside through the remainder of the term.

5.2.3 Any Department Chair or Section Chief shall be automatically removed for failure to meet those responsibilities assigned within these bylaws, failure to comply with policies and procedures of the medical staff, for conduct or statements that damage the hospital, its goals, or programs, or an automatic or precautionary (summary) suspension of clinical privileges. Any Department Chair or Section Chief can be removed by the Chief of Staff based on the recommendation of a majority of the Active Members of the Department or Section. If any Department Chair or Section Chief fails to promptly fulfill assigned responsibilities, the MEC may take action to fulfill the responsibilities, or the MEC may temporarily delegate the responsibilities to another Medical Staff Member.

5.3 Responsibilities of Department Chair

a. To oversee all clinically-related activities of the Department;

b. To oversee all administratively-related activities of the Department, unless otherwise provided by the hospital;
c. To provide ongoing surveillance of the performance of all individuals in the medical staff Department who have been granted clinical privileges;

d. To recommend to the credentials committee the criteria for requesting clinical privileges that are relevant to the care provided in the medical staff Department;

e. To recommend clinical privileges for each member of the Department and other licensed independent practitioners practicing with privileges within the scope of the Department;

f. To assess and recommend to the MEC and hospital administration off-site sources for needed patient care services not provided by the medical staff Department or the hospital;

g. To integrate the Department into the primary functions of the hospital;

h. To coordinate and integrate interdepartmental and intradepartmental services and communication;

i. To develop and implement medical staff and hospital policies and procedures that guide and support the provision of patient care services and review and update these, at least triennially, in such a manner to reflect required changes consistent with current practice, problem resolution, and standards changes;

j. To recommend to the CEO sufficient numbers of qualified and competent persons to provide patient care and service;

k. To provide input to the CEO regarding the qualifications and competence of Department or service personnel who are not LIPs but provide patient care, treatment, and services;

l. To continually assess and improve of the quality of care, treatment, and services;

m. To maintain quality control programs as appropriate;

n. To orient and continuously educate all persons in the Department; and

o. To make recommendations to the MEC and the hospital administration for space and other resources needed by the medical staff Department to provide patient care services.

5.4 Assignment to Department

The MEC will, after consideration of the recommendations of the Chair of the appropriate Department, recommend Department assignments for all members in accordance with their qualifications. Each member will be assigned to one primary Department; the member shall only vote in their primary Department. Clinical privileges are independent of Department assignment.
Section 6. Committees

6.1 Designation and Substitution

There shall be a Medical Executive Committee (MEC) and such other standing and ad
hoc committees as established by the MEC and enumerated in the Organization and
Functions Manual, a part of the Rules & Regulations. Meetings of these committees will
be either regular or special. Those functions requiring participation of, rather than direct
oversight by the medical staff may be discharged by medical staff representation on
such hospital committees as are established to perform such functions. The Chief of
Staff may appoint ad hoc committees as necessary to address time-limited or
specialized tasks.

6.2 Medical Executive Committee (MEC)

6.2.1 Committee Membership:

a. Composition: The MEC shall be a standing committee consisting of the
following voting members: the officers of the Medical Staff, the Immediate
Past Chief of Staff, all Department Chairs, the Chair of the Medical Staff
Quality Improvement (MSQI) Committee, and MEC At-Large Members who
shall number one (1) per two hundred fifty (250) Active Members. The chair
will be the Chief of Staff. There shall be the following ex-officio members
without vote: CEO, CMO, CNO, VP of Quality and other service cine chairs
as the MEC determines.

b. Removal from MEC: An officer, MEC At-Large Member, or Department
Chair who is removed from his/her position in accordance with Section 4.7
and/or Section 5.2 above will automatically lose his/her membership on the
MEC. When the chair of any committee with a designated MEC position or a
Department Chair resigns or is removed from these positions, his/her
replacement will serve on the MEC. When a member of the MEC who was
elected at-large resigns or is removed, the MEC will arrange for an at-large
election for a replacement to serve out the remainder of the vacated term if
the unexpired term is greater than six (6) months. If the unexpired term is
six (6) months or less, the MEC shall appoint an Active Member to replace
the MEC At-Large Member. Such an election will follow procedures
established by the MEC and must take place within sixty (60) days of the
removal of an MEC member.

6.2.2 Duties:

The duties of the MEC, as delegated by the medical staff, shall be to:

a. Serve as the final decision-making body of the medical staff in accordance
with the medical staff bylaws and provide oversight for all medical staff
functions;

b. Coordinate the implementation of policies adopted by the Board;

c. Submit recommendations to the Board concerning all matters relating to
appointment, reappointment, staff category, Department assignments,
clinical privileges, and corrective action;
d. Report to the Board and to the staff for the overall quality and efficiency of professional patient care services provided by individuals with clinical privileges and coordinate the participation of the medical staff in organizational performance improvement activities;

e. Take reasonable steps to encourage and monitor professionally ethical conduct and competent clinical performance on the part of practitioners with privileges including collegial and educational efforts and investigations, when warranted;

f. Make recommendations to the Board on medical administrative and hospital management matters;

g. Keep the medical staff up-to-date concerning the licensure and accreditation status of the hospital;

h. Participate in identifying community health needs and in setting hospital goals and implementing programs to meet those needs;

i. Review and act on reports from medical staff committees, Departments, and other assigned activity groups;

j. Formulate and recommend to the Board medical staff rules, policies, and procedures;

k. Request evaluations of practitioners privileged through the medical staff process when there is question about an applicant or practitioner’s ability to perform privileges requested or currently granted;

l. Make recommendations concerning the structure of the medical staff, the mechanism by which medical staff membership or privileges may be terminated, and the mechanisms for fair hearing procedures;

m. Consult with administration on the quality, timeliness, and appropriateness of contracts for patient care services provided to the hospital by entities outside the hospital;

n. Oversee that portion of the corporate compliance plan that pertains to the medical staff;

o. Hold medical staff leaders, committees, and Departments accountable for fulfilling their duties and responsibilities;

p. Make recommendations to the medical staff for changes or amendments to the medical staff bylaws; and

q. The MEC is empowered to act for the organized medical staff between meetings of the organized medical staff.

6.2.3 Meetings: The MEC shall meet at least 10 times per year and more often as needed to perform its assigned functions. Permanent records of its proceedings and actions shall be maintained.
Section 7.  Medical Staff Meetings

7.1  Medical Staff Meetings

7.1.1 If conducted, an annual meeting and other general meetings, if any, of the medical staff shall be held at a time determined by the Chief of Staff or the MEC. Notice of the meeting shall be given to all medical staff members via appropriate media and posted conspicuously.

7.1.2 Except for bylaws amendments or as otherwise specified in these bylaws, the actions of a majority of the members present and voting at a meeting of the medical staff is the action of the group. Action may be taken without a meeting of the medical staff by presentation of the question to each member eligible to vote, in person, via telephone, and/or by mail or Internet, and their vote recorded in accordance with procedures approved by the MEC. Such vote shall be binding so long as the question that is voted on receives a majority of the votes cast.

7.1.3 Special Meetings of the Medical Staff

a. The Chief of Staff may call a special meeting of the medical staff at any time. The Chief of Staff must call a special meeting if so directed by resolution of the MEC. Such request or resolution shall state the purpose of the meeting. The Chief of Staff shall designate the time and place of any special meeting.

b. Written or electronic notice stating the time, place, and purposes of any special meeting of the medical staff shall be conspicuously posted and shall be sent to each member of the medical staff at least three (3) days before the date of such meeting. No business shall be transacted at any special meeting, except that stated in the notice of such meeting.

7.2  Regular Meetings of Medical Staff Committees and Departments

Committees and Departments may, by resolution, provide the time for holding regular meetings without notice other than such resolution. Departments shall meet at least once per year.

7.3  Special Meetings of Committees and Departments

A special meeting of any committee or Department may be called by the committee chair or Chief or of the Department thereof or by the Chief of Staff.

7.4  Quorum

7.4.1 Medical Staff Meetings: Those eligible medical staff members present and voting on an issue, but not less than three (3).

7.4.2 MEC, Credentials & Privileges Committee, and the Medical Staff Quality Improvement Committee: A quorum will exist when no less than five (5) members are present. When dealing with Category 1 (streamlined) requests for routine appointment, reappointment, and clinical privileges the MEC quorum will consist of at least three members.

7.4.3 Department meetings or medical staff committees other than those listed in section 7.4.2, those present and eligible medical staff members voting on an issue, but not less than two (2).
7.5 Attendance Requirements

7.5.1 Members of the medical staff are encouraged to attend meetings of the medical staff.

a. MEC, Credentials & Privileges Committee, and the Medical Staff Quality Improvement Committee meetings: Members of these committees are expected to attend at least fifty percent (50%) of the meetings held. Failure to meet the attendance requirement may result in replacement on the committee.

b. Special meeting attendance requirements: Whenever there is a reason to believe that a practitioner is not complying with medical staff or hospital policies or has deviated from standard clinical or professional practice, the Chief of Staff or the applicable Department Chair or medical staff committee chair may require the practitioner to confer with him/her or with a standing or ad hoc committee that is considering the matter. The practitioner will be given special notice of the meeting at least 24 hours prior to the meeting. This notice shall include the date, time, place, issue involved and that the practitioner’s appearance is mandatory. Failure of the practitioner to appear at any such meeting after two notices, unless excused by the MEC for an adequate reason, will result in an automatic termination of the practitioner’s membership and privileges. Such termination would not give rise to a fair hearing, but would automatically be rescinded if and when the practitioner participates in the previously referenced meeting.

c. Nothing in the foregoing paragraph shall preclude the initiation of precautionary (summary) restriction or suspension of clinical privileges as outlined in Investigations, Corrective Action, Hearing and Appeal Plan.

7.6 Participation by the CEO

The CEO or his/her designee may attend general, committee, or Department meetings of the medical staff as an ex-officio member without vote. Attendance at an Executive Session of the Medical Staff will be by invitation of the Chief of Staff.

7.7 Meeting Rules of Order

Medical staff and committee meetings shall be run in a manner determined by the chair of the meeting.

7.8 Notice of Meetings

Written or electronic notice stating the place, day, and hour of any special meeting or of any regular meeting not held pursuant to resolution shall be delivered or sent to each member of the Department or committee not less than three (3) days before the time of such meeting by the person or persons calling the meeting. The attendance of a member at a meeting shall constitute a waiver of notice of such meeting.

7.9 Action of Committee or Department

The recommendation of a majority of its members present at a meeting at which a quorum is present shall be the action of a committee or Department. Such recommendation will then be forwarded to the MEC for action.
7.10 **Rights of Ex officio Members**

Except as otherwise provided in these bylaws, persons serving as ex officio members of a committee shall have all rights and privileges of regular members, except that they shall not vote, be able to make motions, or be counted in determining the existence of a quorum.

7.11 **Minutes**

Minutes of each regular and special meeting of a committee or department shall be prepared and shall include a record of the attendance of members and the vote taken on each matter. The presiding committee chair or Department Chair shall authenticate the minutes and copies thereof shall be submitted to the MEC or other designated committee. A permanent file of the minutes of each meeting shall be ma
Section 8. Conflict Resolution

8.1 Conflict Resolution

8.1.1 In the event the Board acts in a manner contrary to a recommendation by the MEC, involving issues of patient care or safety, the matter may (at the request of the MEC) be submitted to a Joint Conference Committee composed of the officers of the medical staff and an equal number of members of the Board for review and recommendation to the full Board. The committee will submit its recommendation to the Board within thirty (30) days of its meeting.

8.1.2 To promote timely and effective communication and to foster collaboration between the Board, management, and medical staff, the chair of the Board, CEO, or the Chief of Staff may call for a meeting between appropriate leaders, for any reason, to seek direct input, clarify any issue, or relay information directly.

8.1.3 Any conflict between the medical staff and the Medical Executive Committee will be resolved using the mechanisms noted in Sections 2.7.1 through 2.7.4 of these bylaws.
Section 9.  Review, Revision, Adoption, and Amendment

9.1 Medical Staff Responsibility

9.1.1 The medical staff shall have the responsibility to formulate, review at least biennially, and recommend to the Board any medical staff bylaws, rules, regulations, Credentials Manual, Corrective Action and Fair Hearing Plan, policies, procedures, and amendments as needed. Amendments to the bylaws and rules & regulations shall be effective when approved by the Board. The medical staff can exercise this responsibility through its elected and appointed leaders or through direct vote of its membership.

9.1.2 Such responsibility shall be exercised in good faith and in a reasonable, responsible, and timely manner. This applies as well to the review, adoption, and amendment of the related rules, policies, and protocols developed to implement the various sections of these bylaws.

9.2 Methods of Adoption and Amendment to these Bylaws

9.2.1 Proposed amendments to these bylaws may be originated by the MEC or by a petition signed by ten percent (10%) of the members of the Active category.

9.2.2 Each Active member of the medical staff will be eligible to vote on the proposed amendment via printed or secure electronic ballot in a manner determined by the MEC. All Active members of the medical staff shall receive at least thirty (30) days advance notice of the proposed changes. The amendment shall be considered approved by the medical staff by a majority vote of approval, as long as at least ten percent (10%) of the voting medical staff have submitted ballots.

9.2.3 Amendments so adopted shall be effective when approved by the Board.

9.2.4 Urgent Amendments. Notwithstanding the foregoing, if there is an urgent need to amend the Medical Staff Bylaws, Rules and Regulations or polices to comply with law or regulation, the MEC may adopt the necessary amendment provisionally and submit to the Board for provisional approval, without prior notification of the Medical Staff. Immediately following the MEC’s adoption and the Board’s provisional approval of such urgent provisional amendment, the MEC will notify the Medical Staff and offer the opportunity for any Medical Staff member to submit written comments to the MEC within 30 days of the notice. The amendment will become effective at the end of the comment period if there is substantial conflict regarding the provisional amendment (there is no substantial conflict unless at least 51% of the voting members of the Medical Staff express opposition to the amendment in writing). If the comments indicate a substantial conflict over the provisional amendment, the MEC shall implement the Conflict Management process as set forth in Section 8.1 of these Bylaws and, if necessary, may submit a revised amendment to the Board for approval.
9.3 Methods of Adoption and Amendment to any Medical Staff Rules, Regulations, Credentials Manual, Corrective Action and Fair Hearing Plan, (collectively “Rules and Regulations”) and Policies and Procedures

9.3.1 The medical staff may adopt additional rules, regulations, and policies as necessary to carry out its functions and meet its responsibilities under these bylaws. A Rules and Regulations and/or Policies Manual may be used to organize these additional documents.

9.3.2 The MEC shall vote on the proposed language changes at a regular meeting, or at a special meeting called for such purpose. Following an affirmative vote by the MEC, Rules and Regulations may be adopted, amended, or repealed, in whole or in part and such changes shall be effective when approved by the Board. Policies and procedures will become effective upon approval of the MEC.

9.3.3 In addition to the process described above, the organized medical staff itself may recommend directly to the Board an amendment(s) to any Rule and Regulation, or policy by submitting a petition signed by ten percent (10%) of the members of the Active category. Upon presentation of such petition, the adoption process outlined in 9.2.1 above will be followed.

9.4 Technical or legal modifications, or clarifications.

9.4.1 The MEC, in the committee’s judgment, may adopt such amendments to these bylaws, Rules and Regulations, and policies. Such modifications may include reorganization or renumbering, punctuation, spelling, or other errors of grammar or expression. Such amendments need not be approved by the entire Board but must be approved by the hospital CEO. Neither the organized medical staff nor the Board may unilaterally amend the medical staff bylaws or rules and regulations.