

IN THE UNITED STATES DISTRICT COURT FOR THE
WESTERN DISTRICT OF MISSOURI
CENTRAL DIVISION

COMPREHENSIVE HEALTH OF PLANNED)
PARENTHOOD GREAT PLAINS, et al.)

Plaintiffs,)

v.)

Case No. 2:16-cv-04313-HFS

PETER LYSKOWSKI, in his official capacity)
as Director of the Missouri Department of)
Health and Senior Services, et al.)

Defendants.)

**REPLY SUGGESTIONS IN SUPPORT OF
PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION**

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Under *Whole Woman’s Health v. Hellerstedt*, 136 S. Ct. 2292 (2016) [hereinafter “Whole Woman’s Health” or “WWH”], Missouri’s requirements that facilities that provide abortion be licensed as ambulatory surgical centers¹ (“ASC Restriction”) and physicians who provide abortion have local hospital privileges and/or a transfer agreement with a local hospital² (“Hospital Relationship Restriction”) (together, “the Restrictions”) – which limit the abortion facilities in Missouri to just one – are plainly unconstitutional and should be enjoined. Defendants want to avoid that result, but *Whole Woman’s Health* has already resolved each of the issues they try to dispute: (1) abortion is safe; (2) neither of the Restrictions advance women’s health (in fact they harm women by delaying abortions for some and denying them to others); and (3) the burdens on women, which exceed those imposed by the Texas laws struck by the Supreme Court, cannot be justified.

ARGUMENT

I. Plaintiffs Have Established a Likelihood of Success on the Merits

A. The Challenged Restrictions Do Not Further the State’s Interest in Women’s Health

The evidence Defendants present in an attempt to show the Restrictions promote women’s health merely rehashes the same disputes decided in *Whole Woman’s Health*, and does not show that the Court should reach a different conclusion here.

First, Defendants attempt to justify the Restrictions by claiming that abortion has a “far higher” complication rate than Plaintiffs show. However, as Plaintiffs have explained and Defendants’ medical expert, Dr. Andrew Steele, does not deny,³ abortion is extremely safe.

¹ Mo. Ann. Stat. § 197.200

² Mo. Ann. Stat. § 197.215, Mo. Code Regs. Ann. tit. 19, § 30-30.060(1)(C)(4), Mo. Ann. Stat. § 188.080, and Mo. Ann. Stat. § 188.027(1)(1)(e)

³ This is in spite of the fact that Dr. Steele is actively opposed to abortion, as a member of the American Association of Pro-Life Obstetricians and Gynecologists. Decl. of Andrew Steele,

Suggestions in Supp. of Pls.’ Mot. for Prelim. Inj. (“Pls.’ Opening Br.”), ECF No. 15, at 3, 6–7, 11–13; Decl. of David Eisenberg in Supp. of Pls.’ Mot. for Prelim. Inj., ECF No. 15-3, ¶¶ 5–7 (“Eisenberg Decl.”); Rebuttal Decl. of David Eisenberg in Supp. of Pls.’ Mot. for Prelim. Inj., ¶¶ 3–15, attached hereto as Ex. 1 (“Eisenberg Rebuttal Decl.”). Indeed, the Supreme Court recognized that it is one of the safest procedures in modern medicine, with an exceedingly low rate of complications. *WWH*, 136 S. Ct at 2311.

Faced with this clear safety data, Defendants claim, without evidence, it does not apply to Missouri, State Defs.’ Suggestions in Opp. to Pls.’ Mot. for Prelim. Inj., ECF No. 28 (“State Defs.’ Br.”) at 11, but there is nothing unique about abortion in Missouri that would make national data, relied on by the Supreme Court as well as Plaintiffs’ expert, unreliable. Eisenberg Rebuttal Decl. ¶ 5. Defendants do not even attempt to argue that the Restrictions decrease the rate of abortion complications in Missouri or affect how those complications are treated, nor could they.⁴ *Id.* ¶ 15. Defendants also try to argue that data from peer-reviewed journals significantly under-reports abortion complications, but they provide no evidence to support this argument beyond mere conjecture. Eisenberg Rebuttal Decl. ¶ 3.

With regard to the ASC Restriction, notably, the State Defendants do not even attempt to argue that the Restriction serves any benefit in the context of medication abortion, and they

ECF No. 28-4, at 15. Furthermore, Dr. Steele does not state that he has ever provided abortion, in contrast to Plaintiffs’ medical expert who is an experienced provider. Defendants’ expert Dr. Solanky also attempts to offer opinions about the safety of abortion but he is a statistician, not a physician, and does not claim to have any medical knowledge whatsoever.

⁴ Misleadingly, they claim that “empirical evidence” shows that hospitalization for post-abortion complications is “relatively common” in the St. Louis area. State Defs.’ Br. at 11. But they rely only on Dr. Steele’s anecdotal experience and he provides absolutely no details about the patients he states he has cared for in the hospital. And Dr. Steele’s similarly anecdotal statements about “communication problems” are not the norm and are contradicted by Plaintiffs’ medical expert, the Medical Director of the only abortion facility in St. Louis, who has provided detailed information about how Planned Parenthood ensures communication in the rare even that a patient is treated in a hospital. Eisenberg Decl. ¶ 46; Eisenberg Rebuttal Decl. ¶ 19.

ignore the fact that their expert Dr. Steele also effectively concedes that it serves no benefit in the context of first trimester surgical abortion, which is when the vast majority of abortions occur. *See* Steele at ¶ 9 (“It is my opinion that facilities performing surgical abortions in the second trimester should follow guidelines expected of any [ASC].”). This alone is fatal to the State Defendants’ defense of the ASC Restriction. Indeed, Defendants’ only argument to justify it is the false claim that surgical abortion is invasive surgery and therefore “rais[es] the same health and safety concerns as other procedures conducted in [ASCs].”⁵ State Defs.’ Br. at 11. The clear record evidence shows, however, that surgical abortion does not involve an incision or entry in a sterile body cavity, and only involves local anesthesia or moderate sedation.⁶ Eisenberg Decl. ¶¶ 9, 24. Indeed, the Supreme Court held that ASC requirements are “inappropriate” for surgical abortion for these very reasons. *WWH*, 136 S. Ct. at 2315–16 (holding that an ASC requirement in the context of abortion “does not benefit patients and is not necessary”). The State Defendants’ attempt to re-litigate this issue should be rejected.

Similarly, the State Defendants should not be permitted to re-litigate whether the Hospital Relationship Restriction advances women’s health: as the Supreme Court held, it clearly does not. *WWH*, 136 S.Ct. at 2311 (stating that, in the rare event of a complication requiring hospital treatment, “the quality of care that [a] patient receives is not affected by whether the abortion provider has [] privileges”). Despite this, the State Defendants make several unavailing

⁵ The State Defendants’ reliance upon professional organizations, including the American College of Surgeons and the American Society of Anesthesiologists, State Defs.’ Br. at 11–12, is misplaced, as none of these professional organizations suggests that abortion needs to be performed in an ASC, and indeed the ASA approves the use of anesthesia in an office setting. Eisenberg Rebuttal ¶ 26, 28. Similarly, the argument that the ASC Requirement is in line with other ASC guidelines, State Defs.’ Br. at 11–12, misses the point entirely: Applying ASC requirements to facilities in which abortion is provided is medically unnecessary. Eisenberg Rebuttal Decl. ¶ 29.

⁶ Plaintiffs do not offer “heavy sedation,” State Defs.’ Br. at 11, despite Defendants’ erroneous claim to the contrary. Eisenberg Decl. ¶ 17; Eisenberg Rebuttal Decl. ¶ 24.

arguments to try to justify the Restriction.⁷ First, they argue that it is “akin to abandonment of the patient” not to have local hospital privileges. However, it is undisputed that the American College of Obstetricians and Gynecologists, the leading professional group for women’s health care, does not require that physicians who provide abortion have hospital privileges. Defendants’ reliance on the American College of Surgeons (“ACS”) is misplaced, as ACS’ recommendations are geared toward general surgery, which is more invasive than abortion.⁸ Eisenberg Rebuttal Decl. ¶ 16. The record evidence is clear that, far from “abandonment,” it is common and consistent with the standard of care for outpatient physicians to transfer care of their patients to hospital-based physicians. Eisenberg Rebuttal Decl. ¶ 19.

Defendants also try to justify the Hospital Relationship Restriction by arguing that “personal post-operative care by the surgeon” is important, State Defs.’ Br. at 12, and that there is evidence of poor communication between abortion providers and emergency department personnel. Aside from these assertions being factually wrong, Eisenberg Decl ¶¶ 39–40; Eisenberg Rebuttal Decl. ¶¶ 19, 21, the Restriction does not require that abortion providers directly treat patients in the event of complications, nor that abortion providers even

⁷ Defendant Patterson (but notably not the State Defendants) relies on *Woman’s Health Center of West County, Inc. v. Webster*, 871 F.2d 1377, 1381 (8th Cir. 1989), which reviewed a prior version of Missouri’s criminal privileges law. Def. Patterson’s Suggestions in Opp. to Pls.’ Mot. for Prelim. Inj., ECF No. 29, at 7-8 (“Patterson”). However, *Webster* is wholly inconsistent with *Whole Woman’s Health*. Moreover, the prior Missouri law required only that physicians performing abortions have privileges at any hospital regardless of location which the court recognized had no effect on the availability of abortion. Here, not only do Plaintiffs’ physicians meet the requirement upheld in *Webster*, but the Restrictions also severely curtail abortion access.

⁸ Defendants also argue that the medical associations associated with gastroenterology and dermatology require that physicians performing colonoscopies and dermatologic surgeries have hospital privileges, but they cite no support for this statement (citing oddly to the association for ear, nose and throat physicians, State Defs.’ Br. 12), and ignore entirely that Missouri does not require physicians performing those procedures to have hospital privileges unless such procedures make up 51% or more of their practice.

communicate with hospital physicians treating their patients. Thus, even if these problems existed—which they do not—the Restriction does nothing to cure them. Indeed, given that the Restriction is currently in effect, Defendants undermine their own argument by simultaneously arguing that there are communication problems and that the Restriction cures those problems.

Defendants also try to justify the Restriction by relying upon the U.S. Food and Drug Administration’s Risk Evaluation and Mitigation Strategy for mifepristone, which requires that providers have the “[a]bility to provide surgical intervention in cases of incomplete abortion or severe bleeding, or to have made plans to provide such care through others, and ability to assure patient access to medical facilities equipped to provide blood transfusions and resuscitation, if necessary.” State Defs.’ Br. at 13. However, this requirement has nothing to do with hospital privileges. Surgical intervention can be provided at an outpatient center, and in the case of an emergency requiring blood transfusion or resuscitation, patients should be seen at their nearest emergency department. In neither case are privileges medically necessary – in fact, a relationship with a hospital is irrelevant to the care a patient receives. Eisenberg Rebuttal Decl. at 10 n. 22.

Finally, Defendants argue that privileges serve a credentialing function that ensures quality physicians. State Defs.’ Br. at 13. It is clear from the record, however, and the Supreme Court has likewise held, that physicians who provide abortion frequently cannot obtain privileges for reasons unrelated to their clinical competence. Eisenberg Decl. ¶¶ 52–53; Decl. of Laura McQuade in Supp. of Pls.’ Mot. for Prelim. Inj., ECF No. 15-1 (“McQuade Decl.”) ¶¶ 21 –25, 28–33; Eisenberg Rebuttal Decl. ¶¶ 30–32; Supplemental Decl. of Laura McQuade, ECF No. 41-1 (“McQuade Suppl. Decl.”) ¶¶ 9-13; *WWH*, 136 S. Ct. at 2312–13. Even if hospital privileges did serve a credentialing function, all of Plaintiffs’ physicians who seek to provide abortions at the four health centers at issue already have hospital privileges—they just don’t have them

within the required geographic distance. Eisenberg Rebuttal Decl. ¶ 17.

Defendants' attempts to re-litigate the medical necessity of the Restrictions fail. *Whole Woman's Health* controls, and the Court must find the Restrictions medically unnecessary.

B. The Restrictions Place Substantial Obstacles on Women's Access to Abortion

In the face of this clear lack of medical necessity, the State Defendants attempt to show that the *Whole Woman's Health* balance comes out differently here because the Missouri restrictions do not impose the same burdens as the invalidated Texas laws. This is untrue.

They first argue that, unlike the Texas laws, the Restrictions have not shut down abortion providers, relying on the waiver process available for some of the ASC Restriction's requirements. However, as is explained in detail in Plaintiffs' Suggestions in Response to State Defendants' Motion to Dismiss, the idea that Missouri's waiver process helps Plaintiffs is a fantasy: the waiver process does not give DHSS the discretion to grant abortion facility licenses to Plaintiffs and, even if it did, DHSS has attempted at every turn to prevent abortion providers from obtaining licenses. Pls.' Suggestions in Opp. to State Defs.' Mot. to Dismiss, ECF No. 41, at 4–5 (“Pls.’ Opp. to Mot. to Dismiss”). Given this, the existence of a waiver process for some of the ASC Restriction's requirements does nothing to alleviate its burdens. Because the ASC Restriction prevents Plaintiffs from providing abortions anywhere but St. Louis, there is no functional difference between it and the Texas law struck in *Whole Woman's Health*.

Second, it is simply false that the ASC and Hospital Relationship Restrictions have been in place for “decades” and that they “have not foreclosed the frequent opening and operation of abortion facilities across the State.” State Defs.' Br. at 8. In fact, the ASC Restriction was amended in 2007 to require facilities that provide abortion to be licensed as ASCs if they provide five or more first trimester abortions or one or more second trimester abortions, drastically

changing its effect. Three clinics that provided abortion at the time remained open only as a result of a lawsuit. *Planned Parenthood of Kansas v. Drummond*, No. 07-4164-CV-C-ODS (W.D. Mo.). As to the Hospital Relationship Restriction, prior to 2005, Missouri's criminal privileges statute did not contain a geographic restriction—rather, physicians who provided abortion were permitted to hold privileges anywhere. However, a 2005 amendment narrowed the requirement to a hospital within 30 miles of the health center at which the physician provides abortion (and the 2006 amendment of the ASC Restriction narrowed that requirement even further, to within 15 minutes travel time of the health center). In 2005, the Hospital Relationship Restriction would have shut down yet another clinic, which was forced to bring a lawsuit to enjoin the statute.⁹ *Springfield Healthcare Ctr. v. Nixon*, No. 05-CV-042960NKL (W.D.Mo.). Similarly, the Columbia health center has been forced to suspend services on various occasions since the Hospital Privileges Requirement was narrowed precisely because it lacked a physician with the privileges required by the amended Restriction. McQuade Decl. ¶¶ 19–26. And Defendants can cite to no new clinics that have opened since the laws were unjustifiably made more onerous.

The State Defendants also attempt to show that the Restrictions have not affected access to abortion, relying on Dr. Solanky. However, Dr. Solanky gets the facts wrong when he attempts to show that changes in the number of abortion providers in the state have not affected the state's abortion rate. Dr. Solanky bases his analysis on the incorrect assumption, provided by counsel, that the number of abortion providers in the state has fluctuated over time. Decl. of Tulumesh K.S. Solanky, ECF No. 28-3, ¶ 14 (“Solanky Decl). But as Plaintiffs' rebuttal expert

⁹ That provider later decided to shut down for unrelated reasons, and the lawsuit was dismissed following entry of a temporary restraining order permitting the physician to continue providing care. Stipulation of Dismissal, No. 05-CV-042960-NKL (W.D.Mo. Oct. 21, 2005), attached hereto as Ex. 2.

in reproductive epidemiology Dr. Stanley Henshaw explains, the overall trend is that the number of providers in the state has steadily declined over time. Rebuttal Decl. of Stanley Henshaw in Supp. of Pls.’ Mot for Prelim. Inj. ¶ 8 (“Henshaw Decl.”), attached hereto as Ex 3. This steady decline has occurred alongside the steady decline in the abortion rate in the state. *Id.*

Furthermore, Dr. Solanky is incorrect that the rate of abortions in Missouri has declined at essentially the same pace as the rate of abortions nationally. Solanky Decl. ¶ 16. In fact, as Dr. Henshaw explains, the best available data shows that over the period from 1990 to 2014, the estimated ratio of abortions to births for the United States fell 40.5%, while the ratio in Missouri fell significantly more over that same time period, 47.5%. Henshaw Decl. ¶ 9. Therefore, the change in the abortion rate does not support Dr. Solanky’s conclusions. Rather, it supports Dr. Henshaw’s testimony, based upon the best available research, that when women are faced with an additional travel burden of 100 miles to reach an abortion provider, 20-25% of women who would have otherwise obtained abortions do not obtain them, and longer distances, such as those faced by Missouri women, will prevent an even higher percentage of women from accessing care. *Id.* ¶ 18, 26 (one-way travel distances to St. Louis of 122 miles from Columbia, 214 miles from Springfield, and 281 miles from Joplin).

Aside from getting the facts wrong, Defendants’ focus on the rate of abortion, and the average driving distance to abortion providers faced by all women of reproductive age in the state, is misplaced as a matter of law. Under clear Supreme Court precedent, in analyzing the burdens the Restrictions impose, the Court must focus on their impact on those women for whom the laws are “an actual rather than an irrelevant restriction.” *WWH*, 136 S. Ct. at 2320 (explaining “large fraction” refers to “a large fraction of cases in which [the provision at issue] is *relevant*,” a class narrower than “all women,” “pregnant women,” or even “the class of *women*”).

seeking abortions identified by the State”) (internal quotations omitted). In this case, the women affected by the Restrictions are those women who reside in or near communities that would have an abortion provider but for the Restrictions. Looking at the effects on all women seeking abortion in the state, or all women of reproductive age in the state, has no bearing on the burdens faced by those women actually affected by the Restrictions.

Defendants’ focus on the abortion rate also inappropriately focuses only on women who are prevented entirely from accessing abortion. This is not the correct legal standard, as court after court, including the Supreme Court, has recognized that burdens short of being entirely prevented from obtaining an abortion constitute a substantial obstacle. *See, e.g., Whole Woman’s Health*, 136 S. Ct. at 2318 (forcing women to obtain abortions at large facilities outside their home communities and to travel long distances to reach those facilities constitutes a substantial obstacle). Indeed, Defendants entirely fail to dispute Plaintiffs’ expert Dr. Sheila Katz, who explains that forcing women to travel long distances to reach an abortion provider increases the cost and logistical difficulty of obtaining an abortion, and that therefore, women who are ultimately able to obtain an abortion in the face of these obstacles are frequently delayed, at increased risk to their health. *See generally* Decl. of Sheila Katz in Supp. of Pls.’ Mot. for Prelim. Inj., ECF No. 15-5; *see also* Henshaw Decl. ¶¶ 19-24. Defendants do not dispute that poor women are most affected by these increased costs and logistical difficulties, nor that these delays may push some women past the gestational age for obtaining a medication abortion, may push some women into the second trimester of pregnancy, and may push still other women past the gestational age at which they could obtain an abortion at all.

Finally, Defendants apply another wrong legal standard when they ask the Court to consider out-of-state abortion providers. Every court to have addressed this question has refused

to do so, as “the proposition that ‘the harm to a constitutional right [can be] measured by the extent to which it can be exercised in another jurisdiction . . . [is] a profoundly mistaken assumption.’” *Planned Parenthood of Wis., Inc. v. Schimel*, 806 F.3d 908, 918 (7th Cir. 2015) (quoting *Ezell v. City of Chicago*, 651 F.3d 684, 697 (7th Cir. 2011)); *Jackson Woman’s Health Org. v. Currier*, 760 F.3d 448, 457 (5th Cir. 2014) (“[A] state cannot lean on its sovereign neighbors to provide protection of its citizens’ federal constitutional rights.”). Moreover, Defendants’ proposed standard was rejected by the Supreme Court in *Whole Woman’s Health*, where the Court refrained from considering the availability of abortion providers outside of Texas. *WWH*, 136 S. Ct. at 2304, 2313, 2316-17 (noting that the court of appeals considered providers in neighboring states, but considering only Texas providers in assessing burden).¹⁰

Therefore, Defendants do nothing to undermine Plaintiffs’ showing that by preventing all but one facility in the state from providing abortion, the Restrictions impose substantial obstacles on women seeking abortion that cannot be medically justified, just like the Texas Restrictions invalidated in *Whole Woman’s Health*. They should, therefore, be enjoined.

C. Each of Defendants’ Motion to Dismiss Arguments is Meritless

Because they have no answer to this binding precedent, the State Defendants also repeat

¹⁰ Even considering out-of-state providers, the substantial distances upon which Defendants rely do nothing to save the Restrictions. Columbia, Missouri is approximately 135 miles from the closest out-of-state provider in Overland Park, Kansas. Henshaw Decl. ¶ 27. Springfield, Missouri is approximately 135 miles from the closest out of state provider in Fayetteville, Arkansas, and Joplin, Missouri is approximately 85.5 miles to Fayetteville. *Id.* And, importantly, the health center in Fayetteville offers only medication abortion up to 9 weeks of pregnancy; therefore, in order for women in the Springfield area to access the surgical abortions that would be available in their own community but for the Restrictions, they would have to travel even further—160 miles—to the next closest out-of-state provider in Overland Park. *Id.* The fact that Comprehensive Health’s Kansas City, Missouri facility is near the Overland Park facility is also of no moment—the Supreme Court rejected the conclusion reached by the Fifth Circuit in *Whole Woman’s Health* that women in El Paso were not harmed because they could simply cross the border and go to a nearby facility in New Mexico. 136 S. Ct. at 2313, 2316-17.

the arguments raised in their Motion to Dismiss that the Court lacks jurisdiction to hear Plaintiffs' claims and that Comprehensive Health's challenge to the ASC Restriction is barred by a prior settlement agreement. As Plaintiffs explain in detail in their Suggestions in Response to State Defendants' Motion to Dismiss, ECF No. 39, these arguments are also meritless.

II. The Remaining Equitable Factors Clearly Weigh in Favor of Plaintiffs

Defendants argue that Plaintiffs have shown only the “possibility” of harm. State Defs.’ Br. at 14. In fact, Plaintiffs have made a robust showing that Missouri women are being harmed on an ongoing basis by the Restrictions. Plaintiffs have shown that long-distance travel to reach an abortion provider is preventing a significant proportion of women from accessing abortion and forcing them to carry their pregnancies to term, Pls. Opening Br. Statement of Facts Section IV; Henshaw Decl. ¶¶ 16–18; Katz Decl. ¶ 31, and that for those women who manage to obtain an abortion, the need for travel causes undue delay, expense, and/or threat to the confidentiality of her pregnancy and abortion decision. Pls. Opening Br. Statement of Facts Section IV; Henshaw Decl. ¶¶ 19–23; Katz Decl. ¶¶ 33–36; McQuade Decl ¶ 49; Decl. of Mary Kogut in Supp. of Pls.’ Mot. for Prelim. Inj., ECF No. 15-2, ¶ 16. Furthermore, being forced to carry a pregnancy to term, or being delayed in obtaining an abortion, threatens women’s health. Eisenberg Decl. ¶ 7, 61. Far from speculative, these harms are certain and ongoing, and clearly constitute irreparable injury. *See* Pls.’ Opening Br. at 22–23 (citing cases); *see also Roe v. Crawford*, 396 F. Supp. 2d 1041, 1043-44 (W.D. Mo. 2005) (delay in obtaining abortion procedure “may cause Plaintiff substantial injury, exposing her to increased medical, financial, and psychological risks” and, thus, constitutes irreparable injury).¹¹

¹¹ Defendant Patterson argues that Plaintiff RHS has not shown that it is irreparably harmed because it is not currently providing abortions in Springfield. Patterson at 5. But Defendant Patterson ignores the fact that RHS is not currently providing abortions *because of the*

Defendants also argue that Plaintiffs delayed filing this litigation and that this should prevent a finding of irreparable injury. State Defs.’ Br. at 15–16. However, as is explained in detail in their response to the Suggestions in Response to State Defendants’ Motion to Dismiss, it is entirely proper for litigants to engage in investigation and negotiation prior to filing a lawsuit, as Plaintiffs did here, and any associated delay does not preclude a preliminary injunction. Pls.’ Opp. to Mot. to Dismiss at 10–11.¹²

Not only have Plaintiffs demonstrated irreparable injury, but their injury plainly outweighs any injury to the State from injunctive relief, and the public interest will only be served by an injunction. Defendants base their entire arguments as to these equitable factors on the idea that Missouri will suffer irreparable harm if the Restrictions are enjoined, but, as Plaintiffs explained in their opening brief, neither the State nor the public has an interest in the enforcement of an unconstitutional law. Pls.’ Opening Br. at 23. Furthermore, because the Restrictions do not actually further women’s health, the state would not be harmed by an injunction. *MKB Mgmt. Corp. v. Burdick*, 954 F. Supp. 2d 900, 913 (D.N.D. 2013) (where state failed to demonstrate abortion restriction furthered women’s health, balance of harms weighed in favor of plaintiffs); *see also Planned Parenthood of Wisconsin, Inc. v. Van Hollen*, No. 13-CV-

Restrictions. Furthermore, he ignores the serious harms RHS’s patients are suffering on an ongoing basis because of the Restrictions.

¹² The cases cited by Defendants are not to the contrary, as they involve far longer, unexplained delays, or entirely different procedural circumstances. *See Novus Franchising, Inc. v. Dawson*, 725 F.3d 885 (8th Cir. 2013) (plaintiff waited seventeen months to seek injunctive relief); *Wreal, LLC v. Amazon.com, Inc.*, 840 F.3d 1244, 1248 (11th Cir. 2016) (plaintiff “failed to offer any explanation for its five-month delay”); *Garcia v. Google, Inc.*, 786 F.3d 733, 746 (9th Cir. 2015) (finding alleged injury as untethered from copyright claim on which injunction was sought; delay further suggested harms claimed did not stem from copyright claim); *Beame v. Friends of the Earth*, 434 U.S. 1310, 1313 (1977) (Marshall, J., in chambers) (finding applicants for stay failed to meet “particularly heavy” burden of persuading Supreme Court justice that balance of equities tipped in their favor where applicants waited the maximum number of days to petition for certiorari, where applicants first sought stay in district court twenty days *after* filing cert petition, and where district court and court of appeals had already denied stay).

465-WMC, 2013 WL 3989238, at *19 (W.D. Wis. Aug. 2, 2013), *aff'd*, 738 F.3d 786 (7th Cir. 2013) (same). In any event, any harm Missouri might suffer is clearly outweighed by the harms women are currently suffering because of the laws. *E.g.*, *Planned Parenthood Minnesota, N. Dakota, S. Dakota v. Daugaard*, 799 F. Supp. 2d 1048, 1077 (D.S.D. 2011) (harms directly affecting personal liberty interests are more severe than harms to state officials from being prevented from carry out official duties).

Defendant Patterson claims that Plaintiffs will not be harmed if their Motion is denied because that would maintain the status quo, Patterson at 2–3, but he ignores that the status quo is causing ongoing irreparable injury to Plaintiffs and their patients. Where this is the case, a preliminary injunction is proper. *See Ferry-Morse Seed Co. v. Food Corn, Inc.*, 729 F.2d 589, 593 (8th Cir. 1984) (recognizing that courts may “grant[] preliminary relief without regard to establishing the status quo, as long as there [i]s a showing of [] irreparable harm. . . .”) (internal quotations omitted).

III. Discovery and a Evidentiary Hearing Are Unwarranted

The State Defendants request fact and expert discovery regarding Plaintiffs’ request for a preliminary injunction, as well as an evidentiary hearing on Plaintiffs’ motion, but neither is warranted. Indeed, discovery during preliminary injunction proceedings “is not the norm.” *Progressive Cas. Ins. Co. v. F.D.I.C.*, 283 F.R.D. 556, 557 (N.D. Iowa 2012) (quoting *Merrill Lynch, Pierce, Fenner & Smith, Inc. v. O’Connor*, 194 F.R.D. 618, 624 (N.D. Ill. 2000)), and when it is granted, the subject matter of the discovery “should be narrowly tailored in scope.” *Id.* (quoting *St. Louis Grp., Inc. v. Metals & Additives Corp.*, 275 F.R.D. 236, 240 (S.D. Tex. 2011) (internal quotation marks omitted)). The party seeking discovery bears the burden of demonstrating need, *Merrill Lynch*, 194 F.R.D. at 623, and must show that “the need for

expedited discovery . . . outweighs prejudice to [the] responding party.” *Monsanto Co. v. Woods*, 250 F.R.D. 411, 413 (E. D. Mo. 2008). The Court should not allow expedited discovery unless it would “better enable the court to judge the parties’ interests and respective chances for success on the merits” at the preliminary injunction stage of the case. *Edudata Corp. v. Scientific Computers, Inc.*, 599 F. Supp. 1084, 1088 (D. Minn. 1984).

The State Defendants have not shown that there is a need for expedited discovery here, and certainly not for the sort of broad, open-ended discovery they seek. In fact, the State Defendants did not specify in their brief what discovery they sought at all. However, in the course of the parties’ discussions under Rule 26(f), when Plaintiffs attempted to seek a compromise regarding this issue, it became clear that the State seeks discovery – over an extended period of time – that essentially amounts to a full litigation of this case.¹³ See Proposed Scheduling Order, ECF No. 43, 3-4. This is improper. *Univ. of Texas v. Camenisch*, 451 U.S. 390, 395 (1981) (“a preliminary injunction is customarily granted on the basis of procedures that are less formal and evidence that is less complete than in a trial on the merits. A party thus is not required to prove his case in full at a preliminary-injunction hearing.”).

Defendants have not even attempted to explain how discovery would better enable the Court to adjudicate Plaintiffs’ motion. On the other hand, the kind of open-ended, lengthy discovery Defendants seek would prejudice Plaintiffs by unnecessarily delaying the adjudication of their motion, compounding the ongoing irreparable injury being suffered by Plaintiffs and

¹³ The State Defendants have said they want discovery prior to the preliminary injunction hearing that includes “the manner in which the ASC requirements and the hospital-privilege requirements in Missouri law and regulations advance state interests in promoting and safeguarding women’s health” and “whether and to what extent the ASC requirements and hospital-privilege requirements pose any substantial obstacle to abortion access,” Proposed Scheduling Order, ECF No. 43 at 3-4. This is, in essence, the entirety of Plaintiffs’ substantive due process claims.

their patients.¹⁴ The evidence already before the Court is more than sufficient for adjudication of Plaintiffs' motion, and Defendants' request for discovery should be denied. However, if discovery is permitted, it should be narrowly limited, tailored to any additional evidence needed at this phase of the case, and expedited, consistent with the federal rules.

An evidentiary hearing is also unnecessary and the Court, in its discretion, may forgo one. *See Bradshaw v. United States*, 153 F.3d 704, 708 (8th Cir.1998). "An evidentiary hearing is required prior to [] a preliminary injunction only when a material factual controversy exists." *United Healthcare Ins. Co. v. AdvancePCS*, 316 F.3d 737, 744–45 (8th Cir. 2002). Here, because Defendants' factual arguments attempt to re-litigate issues that have already been decided by the Supreme Court, there is no genuine issue of material fact. *MKB Mgmt. Corp. v. Stenehjem*, 795 F.3d 768, 772–73 (8th Cir. 2015), *cert. denied*, 136 S. Ct. 981, 194 L. Ed. 2d 4 (2016) (where a party offers evidence that "differs from the Supreme Court's" holdings, this "does not create a genuine dispute") (citing *Churchill Bus. Credit, Inc. v. Pac. Mut. Door Co.*, 49 F.3d 1334, 1336 (8th Cir. 1995) ("A factual dispute is genuine 'if the evidence is such that a reasonable jury could return a verdict for the nonmoving party.'") (internal citations omitted). Because there is no genuine dispute of fact here, there is no need for the delay and expense associated with an evidentiary hearing, and the Court should decide Plaintiffs' motion following oral argument.

CONCLUSION

For the foregoing reasons, and the reasons stated in Plaintiffs' Opening Brief, Plaintiffs Respectfully Request that the Court grant Plaintiffs' Motion for Preliminary Injunction.

¹⁴ Indeed, Defendants have already used their request for discovery as a dilatory tactic, as they waited nearly a month after Plaintiffs filed their Motion for Preliminary Injunction to even mention discovery, State Defs.' Br. at 13, and by continuing to fail to make a proper motion specifying the discovery they seek.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that on January 31, 2017 a copy of the foregoing has been served upon all counsel of record in this action by electronic service through the Court's CM/ECF system.

/s/ Melissa A. Cohen

Melissa A. Cohen

EXHIBIT 1

IN THE UNITED STATES DISTRICT COURT FOR THE
WESTERN DISTRICT OF MISSOURI
CENTRAL DIVISION

COMPREHENSIVE HEALTH OF PLANNED)
PARENTHOOD GREAT PLAINS, et al.)
)
Plaintiffs,)
)
v.) Case No. 2:16-cv-04313-HFS
)
PETER LYSKOWSKI, in his official capacity)
as Director of the Missouri Department of)
Health and Senior Services, et al.)
)
Defendants.)

**REBUTTAL DECLARATION OF DAVID L. EISENBERG IN SUPPORT OF
PLAINTIFFS' MOTION FOR A PRELIMINARY INJUNCTION**

David L. Eisenberg declares the following:

1. I previously submitted a declaration in this case entitled “Declaration of David L. Eisenberg in Support of Plaintiffs’ Motion for a Preliminary Injunction” (“Eisenberg Decl.”), ECF No. 15-3, dated December 12, 2016. A copy of my curriculum vitae was attached to that declaration as Exhibit A. I submit this rebuttal in my personal capacity, and hold the opinions in this declaration to a reasonable degree of medical certainty. My rebuttal represents my opinions alone. I do not speak for or serve as an authorized representative of Washington University School of Medicine or Barnes-Jewish Hospital.

2. I have reviewed the following declarations submitted by Defendants’ experts: Declaration of Andrew Steele, M.D. and Declaration of Tumulesh K. S. Solanky. I offer my opinion on certain assertions in those declarations. The fact that I do not address a particular

statement or assertion in the declarations does not necessarily mean that I agree with the statement or assertion.

Legal Abortion Is A Safe Procedure

3. Dr. Steele and Dr. Solanky's declarations do not effectively contradict the scholarly research I cited in my report that shows that abortion is one of the safest medical procedures in the United States with an extremely low risk of complications and death. Specifically, Drs. Steele and Solanky assert, without basis, that the often-cited studies from respected peer-reviewed journals on which I rely "suffer from problems with data collection and reporting," Decl of Andrew Steele, M.D., ECF No. 28-4, ¶18 ("Steele Decl."), in particular because, they argue, data is "self-report[ed]" by physicians who provide abortion. Decl. of Tumulesh K. S. Solanky, ECF No. 28-3, ¶ 21 ("Solanky Decl."). The implication that physicians who provide abortions fail to accurately report abortion complications is wholly without basis. Indeed, many studies throughout medicine rely on data that is reported by the physicians providing the care, and those self-reports do not make those studies unworthy of credence. Like the studies on which I rely, such studies are published in peer-review journals, and often represent the best data we have for making decisions about patient care.

4. Furthermore, I do not believe that the studies I cite rely upon data that underreports complications because, in my experience, physicians who provide abortion become aware of most complications, especially serious complications, that arise post-procedure because their patients report them either at a follow-up visit or by a separate phone call. Similarly, the criticism that studies cannot be credited if some study subjects are "lost to follow-up," Steele Decl. ¶ 18.a, does nothing to undermine the research I cite. Physicians rely all the time on studies

regarding the safety of procedures in which some patients are lost to follow-up—very few studies can or do follow up with every patient—but that does not make those studies unreliable.

5. Nor do I agree with Dr. Solanky’s statement that data from throughout the United States is not applicable to Missouri. There is nothing unique about abortion in Missouri as compared with its neighboring states, or indeed the rest of the United States, that would make national data unreliable as to Missouri.

6. Moreover, the studies relied upon by Drs. Steele and Solanky to attempt to assert that complication rates and mortality rates for abortion are higher than the rates I put forth in my initial declaration are studies that are outdated, have been thoroughly discredited, suffer from significant problems that make the data unreliable, or are not appropriate comparators.

7. For example, in an attempt to refute the clear data that less than 1% of women obtaining first-trimester abortions experience minor complications, Dr. Steele relies upon two studies that include as “complications” events that are not complications at all. Steele Decl. ¶¶ 15-16. The first is an outlier study from Finland, *id.* ¶ 16, that reports rates of hemorrhage following abortion that were based on patient self-reports rather than documented complications and are 20-100 times higher than the rates reported in the rest of the published literature. Indeed, the authors of the study themselves have acknowledged that “many of the ‘complications’ are not really such, but rather concerns or adverse events that bring women back to the health care system.”¹ The second study, *id.* ¶ 15, includes in the group of patients who experienced a

¹ Maarit Niinimäki, et al., *Immediate Complications after Medical Compared with Surgical Termination of Pregnancy*, Author Reply, 115 *Obstet Gynecol* 660-1 (2010); see also David A. Grimes & Elizabeth G. Raymond, *Medical Abortion for Adolescents*, 342 *BMJ* d2185 (2011) (“The alarmingly high ‘adverse event’ rates in both adolescents and adults reported by Niinimäki and colleagues, which range from 20 to 100 times higher than recent large studies with more specific outcome definitions, should be interpreted with caution because the reported outcomes were mainly office visits by the worried well and not validated complications. For example, the

complication patients who required reaspiration during their initial abortion appointment because of inadequate visualization of tissue on pathologic examination of the products of conception.² Such a reaspiration is not a complication,³ and yet the study notes that reaspiration was the most frequent “complication” encountered. For these reasons, the complication rates found in these studies are grossly inflated.

8. Another study Dr. Steele relies upon to argue that the complication rate is higher than the rate I put forth in my initial declaration actually is consistent with the studies I rely upon.⁴ *Id.* ¶ 18.a. In particular, this study shows an extremely low major complication rate of only .23% and, importantly, this study also notes that “[w]omen receiving abortion care at hospitals or physician’s offices or groups were significantly more likely to have a complication than women receiving care at outpatient clinics.” Furthermore, while the study reports an overall complication rate of 2.1, this rate is inflated for several reasons. First, this study includes as complications incomplete medication abortions which required aspiration or additional medication, even though these are not complications but rather an expected result from some

outcome of ‘haemorrhage’ was neither defined nor measured because clinicians and patients are notoriously inaccurate at estimating vaginal blood loss.”) Despite this, Dr. Steele attempts to rely upon this inflated data, along with data regarding only certain types of complications from colonoscopies, to argue that abortion is less safe than colonoscopy. In fact, the serious complication rate from a colonoscopy—0.28%—is greater than the serious complication rate following abortion. American Society for Gastrointestinal Endoscopy Standards of Practice Committee, *Guideline: Complications of Colonoscopy*, 74 *Gastrointestinal Endoscopy* 745-46 (2011).

² Lyndsey S. Benson et al., *Safety of Outpatient Surgical Abortion for Obese Patients in the First and Second Trimesters*, 128(5) *Obstet Gynecol* 1065 (Nov. 2016)

³ See Kelly Cleland, Mitchell Creinin, Deborah Nucatola, Montsine Nshom & James Trussell, *Significant Adverse Events and Outcomes After Medical Abortion*, 121(1) *Obstet Gynecol* 166 (Jan. 2013).

⁴ Ushma D. Uphadhyay et al., *Incidence of Emergency Room Visits and Complications After Abortions*, 125(1) *Obstet Gynecol* 175 (2015).

number of medication abortions.⁵ Furthermore, the study notes that the population studied, Medicaid beneficiaries in California, has greater health risks and may have more health problems than the general population, which “would mean that the reported complication rate is overestimated.”⁶ The study’s authors caution against generalizing the data for this reason. Accounting for these various forms of over-reporting, this study shows a complication rate that is comparable to those I cite in my initial report.

9. Similarly, the studies relied upon by Dr. Solanky to assert that the complication rates for medication abortion are higher than those I indicated in my initial declaration, Solanky Decl. ¶¶ 19-20, are obsolete, as they rely upon data regarding patients who were administered an old medication regimen that is no longer utilized and that had higher complication rates than the current regimen used by Planned Parenthood and by physicians who provide abortion in the U.S. generally.⁷ We now have safety and efficacy data, including the research cited in my initial declaration, from hundreds of thousands of medication abortions using the current regimen, which involves a lower dosage of mifepristone and a higher dosage of misoprostol with different routes of administration. All of these data reflect that medication abortion is an extremely safe procedure, and is significantly safer and more effective as currently provided than as provided in the regimen utilized immediately following FDA approval of medication abortion in 2000.⁸

10. Drs. Steele and Solanky rely upon similarly problematic studies to imply that there is a significant risk of death from abortion, and to try to undermine my statements in my

⁵ See Cleland et al., *supra* n. 3

⁶ Uphadhyay et al., *supra* n. 4, at 182

⁷ Jillian T. Henderson, Ann C. Hwang, Cynthia C. Harper, Felicia H. Stewart, *Safety of Mifepristone Abortions in Clinical Use*, 72(3) *Contraception* 175 (Sept. 2005); Richard Hausknecht, *Mifepristone and Misoprostol for Early Medical Abortion: 18 months experience in the United States*. 67(6) *Contraception* 463 (June 2003)

⁸ ACOG Practice Bulletin No. 143 (March 2014)

prior declaration that the risk of death from childbirth is approximately 14 times higher than that associated with abortion. In particular, Dr. Steele argues that “issues” with the data make such a comparison unreliable. Steele Decl. ¶ 18.d. However, as I explained above, the studies I rely upon are published in respected peer-reviewed journals and are reliable. Indeed, the Raymond and Grimes study I cite for this statistic relies on data from the Centers for Disease Control and Prevention (“CDC”), the nation’s leading tracker of vital statistics. The CDC does not just rely on self-reporting by physicians who provide abortion, as Dr. Steele suggests. Rather, it engages in a rigorous process in which medical epidemiologists review the clinical reports and autopsy reports for each death that is possibly related to abortion to determine whether the death is indeed abortion-related.⁹

11. Furthermore, the data cited by Dr. Steele to attempt to undermine this statistic do no such thing. First, Dr. Steele implies that abortion has higher mortality rates than childbirth by citing a study that does not even measure these rates, but rather shows death rates during a 10 year period following abortion and childbirth for any reason, including for example, deaths from accidents, circulatory diseases, and AIDS.¹⁰ Steele Decl. ¶ 18.c. This study sheds no light whatsoever on the relative risks of abortion vs. childbirth. Furthermore, the authors of this study are well-known anti-abortion activists,¹¹ and this study has been determined to be of “poor

⁹ See Karen Pazol et al., *Abortion Surveillance—United States 2012*, Centers for Disease Control and Prevention (Nov. 27, 2015), <https://www.cdc.gov/mmwr/preview/mmwrhtml/ss6410a1.htm> Epidemiologists at the CDC rely on a variety of sources to identify deaths potentially related to abortion, including “state vital records; media reports, including computerized searches of full-text newspaper and other print media databases; and individual case reports by public health agencies, including maternal mortality review committees, health-care providers and provider organizations, private citizens and citizen groups.” *Id.*

¹⁰ David C. Reardon, et al., *Deaths Associated with Pregnancy Outcome: A Record Linkage Study of Low Income Women*, 95 So. Med. J. 834 (2002)

¹¹ See Emily Bazelon, *Is There a Post-Abortion Syndrome*, N. Y. Times Magazine, Jan. 21, 2007 http://www.nytimes.com/2007/01/21/magazine/21abortion.t.html?pagewanted=all&_r=0

quality” by the Academy of Medical Royal Colleges¹² and to have severe methodological limitations by the American Psychological Association.¹³

12. In any event, even if Dr. Steele were correct that there are “issues” with abortion and maternal mortality data, the data would have to be extraordinarily flawed to account for a 14-fold increase in death risk. Minor issues with the data, even if they existed, would not even come close to altering the fact that abortion is considerably safer than carrying a pregnancy to term.

13. Dr. Steele also implies that there is a significant risk of death from infection following medication abortion by pointing to data regarding the risk of clostridium infection. Steele Decl. ¶ 17. Far from showing that this is a significant risk, only nine patients out of the over two million patients who have had a medication abortion in the U.S. have contracted a fatal infection. Not only is that a low mortality rate, the data Dr. Steele cites is once again almost entirely based on data regarding an outdated medication abortion regimen that is no longer used by Planned Parenthood or most other physicians who provide abortions. Furthermore, the FDA studied all of the deaths and the current FDA-approved final printed label for mifepristone specifically states that “[n]o causal relationship between the use of Mifeprex and misoprostol and [fatal infections] has been established.”¹⁴ Indeed, a 2009 study that included researchers from the CDC and others to investigate a possible relationship between medication abortion and *Clostridium* infection determined that gynecological *Clostridium* infection can occur not only

¹² Academy of Medical Royal Colleges & National Collaborating Centre for Mental Health, *Induced Abortion and Mental Health: A Systematic Review of the Mental Health Outcomes of Induced Abortion, Including their Prevalence and Associated Factors*. (2011)

¹³ Task Force on Mental Health and Abortion. *Report of the Task Force on Mental Health and Abortion*. American Psychological Association (2008)

¹⁴ FDA, Mifeprex Label (March 2016).

after medication abortion but also after childbirth, miscarriage, surgical abortion, or injury.¹⁵

ACOG has reached the same conclusion, stating:

Although concern regarding serious, rare, and deadly infection with clostridial bacteria in women who undergo medical abortion has been raised, it has since become evident that no specific connection exists between clostridial organisms and medical abortion. Investigations have found these organisms also are associated with other obstetric and gynecologic processes and procedures, including spontaneous abortion [i.e. miscarriage], term delivery, surgical abortion, and cervical cone or laser treatment for cervical dysplasia. In addition, it is now recognized that clostridial species are a more common cause of pelvic infection than previously believed.¹⁶

Not only is the evidence inconclusive as to whether medication abortion has caused a single fatal infection, but a recent study of the medication abortion regimen Plaintiffs currently use examined six years worth of data and found no deaths due to infection out of 711,556 medication abortions.¹⁷

14. Finally, Dr. Solanky cites a study that shows that the risk of death from abortion increases with gestational age. Solanky Decl. ¶ 18. As an initial matter, because the vast majority of abortions in the United States take place in the first trimester, the overall death rate remains extremely low. But, importantly, Dr. Solanky is correct that death rates increase with gestational age and this is consistent with my statement in my initial declaration that gestational age is an important determinant of medical risk. As the study cited by Dr. Solanky shows, any medically unnecessary obstacles to obtaining an abortion, such as Missouri's ASC and hospital privileges requirements, that delay women's access to abortion harm their health by increasing the risk of the procedure.

¹⁵ Christine S. Ho et al., *Undiagnosed Cases of Fatal Clostridium Associated Toxic Shock in Californian Women of Childbearing Age*, 201 Am. J. Obstetrics & Gynecology 459 (Nov. 2009).

¹⁶ ACOG Practice Bulletin No. 143 at 8 (citations omitted).

¹⁷ James Trussell et al., *Reduction in Infection-Related Mortality since Modifications in the Regimen of Medical Abortion* 89 Contraception 193, 195 (2014).

15. For all of these reasons, I disagree with Defendants' experts about the safety of abortion and stand by the data and opinions in my original declaration.¹⁸ But even if Defendants' experts were correct that abortion complications and abortion-related deaths were underreported – which I do not believe to be the case – this would not change the fact that, as I explain below and in my initial declaration, Missouri's ASC and hospital privileges requirements are medically harmful rather than necessary and would not affect the care patients receive on the rare occasions when complications do occur.

The Hospital Relationship Restriction Is Not Medically Necessary

16. I disagree with Dr. Steele's statement that it is outside of the standard of care for physicians to provide abortion without local hospital privileges or a hospital transfer agreement. Steele Decl. ¶ 8. Dr. Steele relies upon a statement by the American College of Surgeons that physicians performing office-based surgery must have admitting privileges at a nearby hospital, or a transfer agreement with another physician who has admitting privileges at a nearby hospital, or maintain an emergency transfer agreement with a nearby hospital.¹⁹ However, this recommendation for general surgery is not the appropriate standard for abortion, which is far less invasive.²⁰ Indeed, the American College of Obstetricians and Gynecologists (ACOG)

¹⁸ Indeed, Dr. Steele seems to admit that abortion is safe in arguing that the lack of adverse events will result in medical personnel being less vigilant about patient care, and that more safety precautions, including the ASC and Hospital Privileges Restrictions, ought to be required. Steele Decl. ¶ 19. This backwards logic that the safer a procedure is the more safety precautions are required is completely inconsistent with the way medicine is practiced.

¹⁹ American College of Surgeons, Patient Safety Principles for Office Based Surgery (2003) <https://www.facs.org/education/patient-education/patient-safety/office-based-surgery>. Notably, this recommendation, for surgeries far more invasive than abortion, does not require physicians to themselves have hospital privileges so long as they have a hospital transfer agreement or a relationship with a physician with privileges, whereas Missouri's Hospital Relationship Restriction does not practically provide any of these less onerous options.

²⁰ Dr. Steele also inappropriately relies upon guidance issued by the American Academy of Otolaryngology, the American Society for Gastrointestinal Endoscopy, the Society of American

specifically distinguishes between “procedures,” which are defined to include “non-incisional diagnostic or therapeutic intervention through a natural body cavity or orifice,” precisely the type of intervention involved in surgical abortion, and other invasive interventions which are considered “surgery.”²¹ As I explained in my initial declaration, given the nature of abortion, ACOG, as well as the leading professional organization of physicians who provide abortion, the National Abortion Federation (“NAF”) do not require that physicians who provide abortion have hospital privileges.²²

17. Furthermore, it is incorrect that requiring physicians to go through the hospital credentialing process to provide outpatient abortions ensures that providers have sufficient training and skill, Steele Decl. ¶ 8, and that physicians are easily able to obtain hospital privileges. *Id.* ¶ 20. As I explained in my initial declaration, hospitals frequently deny privileges for reasons having nothing to do with clinical competency, and this is particularly true as to physicians who provide abortion given hospitals’ religious objection to the procedure or

Gastrointestinal Surgeons, and the American Society of Colorectal surgeons, all of which are inappropriate in this context as they concern entirely different types of surgery, which are far more invasive and pose greater risks than surgical abortion (and are certainly not applicable to medication abortion).

²¹ Definition of “Procedures” related to Obstetrics and Gynecology, American College of Obstetricians and Gynecologists (Nov. 2015) <http://www.acog.org/Resources-And-Publications/Position-Statements/Definition-of-Procedures-Related-to-Ob-Gyn>

²² Dr. Steele also points to the U.S. Food and Drug Administration’s Risk Evaluation and Mitigation Strategy for mifepristone, which requires that providers have the “[a]bility to provide surgical intervention in cases of incomplete abortion or severe bleeding, or to have made plans to provide such care through others, and ability to assure patient access to medical facilities equipped to provide blood transfusions and resuscitation, if necessary.” Steele Decl. ¶ 17; Mifeprix Risk Evaluation and Mitigation Strategy (REMS), U.S. Food and Drug Administration (Mar. 2016) http://www.accessdata.fda.gov/drugsatfda_docs/rems/Mifeprex_2016-03-29_REMS_document.pdf. However, surgical intervention in cases of incomplete abortion or severe bleeding can be provided via a return visit to the health center or to a different outpatient health center rather than a hospital visit. In the case of a true emergency requiring blood transfusion or resuscitation, patients should be seen at their nearest hospital emergency department. In neither case, however, are hospital privileges or a transfer agreement medically necessary – in fact, a relationship with a hospital is irrelevant to the care a patient receives.

reluctance to work with these physicians given the political controversy surrounding abortion. Eisenberg Decl. ¶ 53. And, in any event, even if it were true that hospital privileges serve a credentialing function, each of Plaintiffs' physicians who seek to provide abortions at the four health centers involved in this litigation already have hospitals privileges (they just don't hold privileges within the distance required by the Hospital Relationship Restriction). Eisenberg Decl. ¶ 2; Decl. of Laura McQuade in Supp. of Pls.' Mot. for Prelim. Inj., ECF No. 15-1, ¶ 22, 28.

18. I understand that the State has criticized me and the other Planned Parenthood providers for not applying for privileges at hospitals at which we clearly do not meet the privileging requirements. However, there can be serious, negative consequences to a physician's career if he applies for privileges at a hospital and is denied. For example, applications for new privileges or reappointment at many hospitals require applicants to disclose any instances in which they have been denied privileges in the past. The presence of this kind of information on an application is looked at unfavorably by credentialing committees and could affect the physician's ability to get privileges in the future. Therefore, it is in a physician's best interest to carefully review a hospital's requirements for privileges to ensure he can meet them before submitting an application. As I explained in my original declaration, Eisenberg Decl. ¶¶ 55–58, and as is explained more fully below and with the attached exhibits, I cannot meet the privileging requirements for any of the hospitals in Joplin and Springfield.

19. Dr. Steele is also incorrect that the Hospital Relationship Restriction is necessary to ensure continuity of care. As an initial matter, he argues that the restriction improves patient care in the context of an emergency such as a uterine perforation because the abortion provider knows what happened during the procedure. Steele Decl. ¶ 13. While uterine perforation is a rare complication that occurs during an abortion procedure, a serious perforation may require

immediate transfer of the patient to a hospital for treatment. As I explained in my initial declaration, in this context the standard of care, and what the Planned Parenthood’s Medical Standards & Guidelines requires, is that the abortion provider communicate directly with the staff that will treat the patient at the hospital, during which the provider would inform the receiving staff exactly what had happened during the procedure. Eisenberg Decl. ¶ 39. The abortion provider would also send medical information with the patient in the ambulance. *Id.* Far from amounting to “patient abandonment,” these types of referrals happen in outpatient medicine every day, and medical staff are well-trained to effectively communicate any necessary information to ensure that a patient receives appropriate treatment.²³ These measures ensure continuity of care, and are not affected by whether or not a physician has admitting privileges at a receiving hospital or a transfer agreement with the receiving hospital.

20. It is not a “dis-service” to patients to transfer their care to hospital-based physicians. Steele Decl. ¶ 14. As I explained in my initial declaration, it is not necessary for the transferring physician to have ongoing involvement in a patient’s care, and it is simply no longer typical in modern medicine. Eisenberg Decl. ¶ 50–51. This is not unique to abortion. If, for example, a family practice doctor referred his or her patient to a hospital for necessary surgery (even if that family practice doctor still maintained admitting privileges), the surgeon would “coordinate” the patient’s care in the hospital. In any event, nothing about Missouri’s Hospital Relationship Restriction requires an abortion provider to have ongoing involvement in a patient’s

²³ Dr. Steele implies that, without the Hospital Relationship Restriction, a patient transferred to a hospital would not have access to an appropriate specialist, Steele Decl. ¶ 13. This is simply untrue. As I explained in my initial declaration, emergency department physicians have access to on-call specialists, including ob/gyns, who they can involve in a patient’s care if necessary. Eisenberg Decl. ¶ 40. Indeed, Dr. Steele has served this very role. Steele Decl. ¶ 12.

care, to provide inpatient treatment for the patient, or even to communicate with hospital physicians.

21. Dr. Steele states that he has “provided emergency care for several individuals receiving abortion services in St. Louis in recent years” and has not “received peer-to-peer communication from a local abortion provider directly or through an emergency department physician.”²⁴ Steele Decl. ¶ 12. While I am sorry that has been his experience, it is not the norm. As I explain above and in my initial declaration, Planned Parenthood requires that providers directly communicate with hospitals in the rare event of an emergency transfer, and I myself follow this practice. In the case of a patient who experiences a complication after leaving the abortion provider, she may present to the emergency department without informing the abortion clinic prior to the visit, or the referring abortion clinic may not know what emergency room the patient is going to visit (particularly if she is from out of town, as is often the case).²⁵ However, as I explained in my initial declaration, clinics enhance communication with emergency rooms in these circumstances by providing patients detailed instructions on what to expect, including what level of bleeding or other symptoms constitute cause for concern, as well as a twenty-four hour after-hours line to call. Eisenberg Decl. ¶ 46. Importantly, Dr. Steele does not argue that either he or the emergency department physicians with whom he worked were unable to appropriately care for the patients or that the quality of the care they provided was diminished in any way in these situations.

²⁴ Dr. Steele does not indicate whether in these instances he asked his emergency department colleagues whether there had been any communication between the abortion provider and the emergency department physician or staff.

²⁵ Indeed, in this latter case, as I explained in my initial report, it would be irrelevant where the providing physician might have admitting privileges, because any patient that needed to be seen at an emergency room should not travel farther than the nearest hospital let alone to the hospital where the provider had privileges. Eisenberg ¶ 44.

22. Furthermore, Dr. Steele is wrong to say that emergency room physicians would not “understand” a uterine perforation. Steele Decl. ¶ 13. Emergency medicine physicians are trained to quickly assess the severity of a patient’s illness or injury and provide immediate and necessary care, including for complications from all types of outpatient surgery, which are routinely seen in the emergency department setting. Perforations are not uncommon complications from a variety of outpatient surgeries, including colonoscopies, endoscopies, uterine aspiration for spontaneous abortion (i.e. miscarriage), hysteroscopy (camera in the uterus) and even potentially cystoscopy (camera in the urethra/bladder), and emergency physicians are familiar with assessing these patients and determining the appropriate course of treatment, including involving specialists and surgeons as necessary.

23. Dr. Steele similarly argues that clostridium infections, a rare complication, cannot be handled by emergency room physicians, *id.* ¶ 17, but infection following an abortion is similar to infection following a miscarriage, and emergency medicine physicians provide care to women experiencing miscarriage complications every day. Furthermore, as CDC researchers have explained, “*C. Sordellii* toxic shock syndrome may occur in reproductive-age women regardless of pregnancy status,” and therefore all clinicians, including emergency physicians, “should be aware of common clinical features” and, where these features are present, apply “a high index of suspicion for this syndrome and early aggressive treatment.”²⁶ Notably, it is the clinical *features* of this condition that should raise suspicion, not the patient's gynecological *history*.²⁷ Furthermore, every patient who has a medication abortion at Planned Parenthood is provided with the Mifeprex[®] Patient Medication Guide, a document approved by the FDA, as

²⁶ Letter from Elissa Meites, et al., *Fatal Clostridium sordellii Infections After Medication Abortion*, 363 New England J. Med. 1382, 1383 (2010).

²⁷ *Id.*

well as additional patient education materials required by the Planned Parenthood Medical Standards & Guidelines. These documents detail potential events related to the medication abortion regimen including infection, instruct patients to call the health center with any concerns, and contain information to provide another healthcare provider if they choose to present themselves there rather than return to Planned Parenthood.

The ASC Restriction Is Medically Unnecessary Given the Nature of Abortion

24. Dr. Steele takes issue with my statement in my initial declaration that surgical abortion is not true “surgery” as that term is generally understood, Steele Decl. ¶ 4, but Dr. Steele’s semantic preference is in fact in contrast to that of ACOG which, as I explain above, considers surgical abortion to be a “procedure” and not surgery.²⁸ In any event, this semantic dispute does not affect the nature of the procedure and what is required to perform it safely. As I explain in my initial declaration, surgical abortion does not involve an incision or entry in a sterile body cavity, but rather evacuation of the uterus through the natural body openings of the vagina and cervix, which are naturally colonized by bacteria, and only involves local anesthesia or moderate sedation. It is for these reasons that surgical abortion can be and most often is safely performed in an office-based setting and that an ASC setting is medically unnecessary. As I have previously stated, these steps taken in performing an abortion are identical to those used to manage a spontaneous abortion (miscarriage) with an aspiration procedure, which is not required to be done in an ASC.²⁹

²⁸ Other gynecological “procedures” include colposcopy, hysteroscopy, cystoscopy and more where the procedural and/or anesthetic risks are so low that office-based settings are not only appropriate, they are preferred. Richard D. Urman et al., *Safety Considerations for Office-Based Obstetric and Gynecological Procedures*, 6(1) *Obstet Gynecol* e8 (2014) <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3651543/>

²⁹ Dr. Steele does not even attempt to argue that there is any medical justification for requiring medication abortion to be provided in an ASC. Nor could he, because, as I explained in my

25. Furthermore, Dr. Steele's focus on the instruments used during abortion is misplaced. The instruments he lists are the same instruments that are safely utilized for a variety of office-based gynecological procedures including miscarriage management, uterine biopsies, and even IUD placement.

26. Dr. Steele attempts to bolster the ASC Restriction by implying that the American Society of Anesthesiologists recommends that procedures utilizing levels of anesthesia deeper than local anesthesia should be performed in ASCs, Steele Decl. ¶ 6, but this implication is misleading and false. In fact, the ASA makes no such recommendation. The ASA recommendations specifically permit the practice of anesthesia in a non-ASC office setting and in fact do not limit the level of anesthesia that may be provided in an office.³⁰ And furthermore, Planned Parenthood Federation of America's Medical Standards and Guidelines relating to sedation rely upon and incorporate the ASA's guidelines on office-based anesthesia, as well as other ASA recommendations, and therefore reflect the standard of care for the provision of office-based anesthesia.

27. It is not clear to me what Dr. Steele is attempting to argue with regard to the need to use "sterile technique" during surgical abortion. Steele Decl. ¶ 10. If he is trying to say that clean technique (otherwise known as medical asepsis),³¹ in which the instruments that will enter the uterus are sterile, but, for example, sterile gloves and a sterile surgical field are unnecessary, should be used, then I agree with this. Using this sort of clean technique is the standard of care

original declaration, a medication abortion requires only that a woman take a pill in the health center.

³⁰ See American Society of Anesthesiologists, *Guidelines for Office-Based Anesthesia* (reaffirmed October 15, 2014).

³¹ Association of Professionals in Infection Control (APIC), *Clean vs. Sterile: Management of Chronic Wounds* (2001)
http://www.apic.org/Resource_/TinyMceFileManager/Position_Statements/Clean-Vs-Sterile.pdf

for gynecological procedures performed through the vagina, which is naturally colonized with bacteria, and that do not involve an incision. Similarly, these techniques are used for inserting surgical instruments and catheters in the urethra and bladder without need for a “sterile technique” as performed in a hospital operating room. As I explained in my initial declaration, it is not medically necessary for such procedures to take place in an ASC because there is no need for a sterile environment for these types of procedures. Eisenberg Decl. ¶ 19.

28. If, however, Dr. Steele is trying to argue that surgical abortion requires the kind of sterile technique (otherwise known as surgical asepsis) required for invasive surgery, which includes, for example, the use of sterile gloves and drapes, masks, and isolation of the operative area from the unsterile environment, then this is simply incorrect and inconsistent with the standard of care for surgical abortion. Nationwide, surgical abortion is regularly performed using clean technique in office-based settings, and this is accepted medical practice. Indeed, ACOG’s guidelines for the provision of abortion care do not require that abortions be performed in ASCs; rather, they specifically condemn “[f]acility regulations that are more stringent [for abortion] than for other surgical procedures of similar risk.”³² Dr. Steele’s reliance on guidance to the contrary from the American College of Surgeons that states that physicians who perform office-based surgery should have their facilities accredited by an accrediting body or via state license are inappropriate in this context, as these guidelines are meant for general surgery and not far less invasive procedures like surgical abortion.³³

³² American College of Obstetricians and Gynecologists. *Guidelines for Women's Health Care: A Resource Manual*. 3rd ed. Washington, DC: American College of Obstetricians and Gynecologists; 2007 (P-192).

³³ Patient Safety Principles for Office Based Surgery, *supra* n. 19; *see* Definition of “Procedures” related to Obstetrics and Gynecology, *supra* n. 21

29. Dr. Steele also attempts to justify Missouri's ASC Restriction by arguing that it is comparable to federal ASC guidelines and guidelines of the American Association for Accreditation of Ambulatory Surgical Facilities, but he misses the point that applying ASC requirements to facilities in which abortion is provided is unnecessary for all the reasons I have explained. He furthermore ignores the fact that abortion is singled out under Missouri law as the only type of procedure for which a facility must be licensed as an ASC if it performs some small number of procedures (five in the case of first trimester abortions and one for second trimester procedures). The fact that surgeries of all kinds, including those far riskier than abortion and those that require general anesthesia, may be performed in office settings unless they constitute the majority of that facility's procedures belies any argument that it is medically necessary for abortion to take place in an ASC.³⁴

Communications with Hospitals in the Joplin and Springfield Areas Regarding Privileges

30. Attached as Exhibit A are my communications with a Physician Recruiter with Freeman Health System in Joplin, Missouri, including the hospital bylaws and privileges application that were provided to me. As I stated in my initial declaration, I cannot meet the hospital's requirements for privileges, including the hospital's residency requirements.

31. Attached as Exhibit B are my communications with the Medical Staff Coordinator at Mercy Hospital Joplin, including the staff bylaws that were provided to me. As I stated in my initial declaration, I cannot meet the hospital's requirements for privileges, including the

³⁴ For this reason as well, not one of the standards from the professional groups cited by Dr. Steele are relevant as not one of them suggests that an ASC is required for five medication or first trimester surgical abortions – or for second trimester procedures. Those professional standards and the Missouri law are simply not “parallel” as Dr. Steele tries to portray. Steele Decl. ¶ 6-7.

hospital's requirement that its physicians adhere to the Ethical and Religious Directives for Catholic Health Facilities.

32. Attached as Exhibit C are my communications with physician recruitment staff at Cox Health in Springfield, Missouri, including the staff bylaws that were provided to me. As I stated in my initial declaration, I am unable to meet the hospital's requirements for privileges, including that my inpatient treatment of patients be evaluated during a period of provisional appointment.

Conclusion

33. For all these reasons and those in my prior declaration, it is my opinion that the ASC and Hospital Relationship Restrictions are medically unnecessary and in fact harm patients by restricting access to abortion.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on January 31, 2017

s/ David L. Eisenberg
David L. Eisenberg, MD, MPH

EXHIBIT A

Eisenberg, David

From: [REDACTED]@freemanhealth.com>
Sent: Friday, October 14, 2016 11:50 AM
To: Eisenberg, David
Cc: [REDACTED]
Subject: RE: Staff Privileges and Hospital Bylaws at Freeman Health System

Dr. Eisenberg – I would be more than happy to send you a portion of the Medical Staff Bylaws pertaining to appointments and a pre-application. The Medical Staff Bylaws are approximately 200+ pages and those normally aren't sent out until a full credentialing packet is sent. The first step is the pre-application which I will send to you at the address listed below. You will need to make sure that you notate on the application why you would be wanting privileges/what your utilization would be at Freeman Health System. Once the pre-application and requested documents are submitted, a background check, databank query and phone references are completed. Once these items are obtained, the pre-application is reviewed by our Chief Medical Officer who will determine if a full credentialing packet will be sent. I will get this in the mail today and once you receive it if you have any questions please feel free to contact me.

[REDACTED]
Freeman Health System
Medical Staff Coordinator

[REDACTED]
[REDACTED]
[REDACTED]@freemanhealth.com

From: Eisenberg, David [REDACTED]
Sent: Friday, October 14, 2016 11:13 AM
To: [REDACTED]@freemanhealth.com>; [REDACTED]@freemanhealth.com>
Cc: 'Eisenberg, David' [REDACTED]
Subject: RE: Staff Privileges and Hospital Bylaws at Freeman Health System

Hi Lana & Cheryl,

I am writing to follow up on our email exchange below from last month. I have not heard back from either of you. As you can tell from the time it has taken me to f/u I'm sure you're both busy, but I would appreciate it if you can let me know what the next steps are and what the requirement for privileges are at Freeman. Would it be possible to share Freeman's staff bylaws and/or credentialing manual with me?

Thank you again,

David L. Eisenberg, MD, MPH, FACOG
Medical Director
Planned Parenthood of the St. Louis Region and Southwest Missouri
&
Associate Professor
Washington University in St. Louis School of Medicine
Department of Obstetrics & Gynecology

[REDACTED]

From: [REDACTED]@freemanhealth.com]
Sent: Monday, September 12, 2016 2:38 PM
To: 'Eisenberg, David' [REDACTED]@freemanhealth.com>
Subject: RE: Staff Privileges and Hosptial Bylaws at Freeman Health System

Good afternoon, Dr. Eisenberg,

I am forwarding your email to our medical staff office coordinator, [REDACTED] to address your inquiry.

Regards,

[REDACTED]
Physician Recruiter
Freeman Health System

[REDACTED]
www.joinfreemandocs.com

From: Eisenberg, David [REDACTED]
Sent: Monday, September 12, 2016 11:58 AM
To: [REDACTED]
Subject: Staff Privileges and Hosptial Bylaws at Freeman Health System

Good Morning,

I am writing to request a copy of your facility's staff bylaws, as I am interested in what the requirements are to apply for staff privileges. For your convenience, I have attached a copy of my CV to this email. If you could please forward any relevant credentialing documents on to me I would appreciate it.

Sincerely,

David L. Eisenberg, MD, MPH, FACOG
Medical Director
Planned Parenthood of the St. Louis Region and Southwest Missouri
&
Associate Professor
Washington University in St. Louis School of Medicine
Department of Obstetrics & Gynecology
[REDACTED]
St. Louis, MO 63110



Planned Parenthood of the St. Louis Region and Southwest Missouri

ADVOCATES – The Political Arm of Planned Parenthood of the St. Louis Region and Southwest Missouri

4251 Forest Park Avenue St. Louis, MO 63108

www.plannedparenthood.org/stlouis

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Locally owned, not-for-profit and nationally recognized, Freeman Health System includes Freeman Hospital West, Freeman Hospital East, Freeman Neosho Hospital and Ozark Center – the area’s largest provider of behavioral health services – as well as two urgent care clinics, dozens of physician clinics and a variety of specialty services. With more than 300 physicians on staff representing more than 60 specialties, Freeman provides cancer care, heart and vascular care, neurology and neurosurgery, orthopedics, children’s services and women’s services. Additionally, Freeman is the only Children’s Miracle Network Hospital in a 70-mile radius. For more information, visit www.freemanhealth.com.

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1102 West 32nd Street | Joplin, MO 64804 | 417.347.1111
freemanhealth.com

October 14, 2016

David L. Eisenberg, M.D.
Washington University/St. Louis School of Medicine
Department of Obstetrics & Gynecology

[REDACTED]
St. Louis, MO 63110

Dear Dr. Eisenberg:

I am enclosing an Medical Staff Application Request form. Please complete this application in its entirety. All information must be typed or legibly written. Copies of licensure and certificates must be clear enough to scan into a computer. Do not leave any blanks on the application or the attached forms. If the answer is unknown or is not applicable the area should be marked "N/A" or "unknown". An application that is not completely filled out will be returned. Please submit the completed application and required documents as soon as possible but no later than November 21, 2016. Once the completed application has been received it will be reviewed by the Freeman Chief Medical Officer. Those individuals who meet the threshold criteria for Medical Staff appointment will be sent a Freeman Medical Staff application packet. Individuals who fail to meet the threshold criteria will not be given an application and shall be notified.

In addition to the completed Medical Staff Application Request form, the following items should also be submitted:

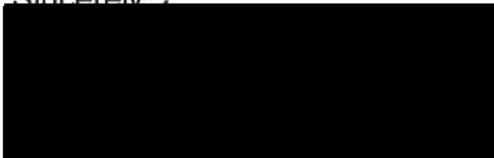
- Copy of current Missouri Medical License
- Copy of current CV
- Copy of current liability insurance coverage
- Freeman Occumed Health History Form (enclosed)
- Request for Data Bank Query (enclosed)
- Consent to Release Information Form (enclosed)
- Authorization for Release of Information for Criminal Background and Reference Check (enclosed)
- \$250 Application Fee (check made out to Freeman Medical Staff)

I have enclosed portions of the Medical Staff Bylaws pertaining to appointment to the Medical Staff:

- categories of the Medical Staff with explanations of the qualifications, prerogatives and responsibilities of each category
- specific qualifications for Medical Staff appointment

The application and required documents should be submitted to the address noted below. If I can be of any assistance to you please let me know and I will be happy to help.

Sincerely,



Medical Staff Services
Freeman Health System
1102 West 32nd St.
Joplin, MO 64804



Categories of the Medical Staff

- (a) All appointments to the Medical Staff shall be made by the Board and shall be to one of the following categories of the staff. All appointees shall designate a primary practice site and shall fulfill their on-call responsibilities. (12-17-98)
- (b) All appointees shall also be assigned to a specific clinical division and have voting privileges only in the division (if on the Active Staff), but shall be eligible for clinical privileges in other divisions as applied for and recommended pursuant to these bylaws, and the Medical Staff Procedural Policy and approved by the Board.
- (c) Medical staff appointees shall only have those prerogatives specified below for their respective category.

Article II – Part A: Active Staff

Section 1. Qualifications:

The Active Staff shall consist of physicians, dentists and podiatrists who meet one or more of the following qualifications:

- (a) Have at least 96 patient contacts during each appointment term; or
- (b) Be party to a contractual relationship (either directly or through a group) for the performance of services for the hospital or any affiliate organization (other than the Freeman Physician Hospital Organization) designated by the hospital.

As used in this Article, the term “patient contact” shall mean an admission to the hospital, and outpatient procedure, or the performance of a consultation on a patient who was not admitted by the appointee in question.

Article II- Part A:

Section 2. Prerogatives:

Appointment to the Active Staff shall carry with it the following prerogatives, subject to other provisions of these bylaws and the Procedural Policy:

- (a) voting at any Medical Staff or division meeting;
- (b) serving on Medical Staff Committees;
- (c) eligibility to hold office; and admit and treat patients at the hospital at the hospital within the scope of their delineated clinical privileges.

Article II- Part A:

Section 3. Responsibilities:

Appointment to the Active Staff shall carry with it the following responsibilities:

- (a) All the responsibilities of membership on the Active Staff, as assigned, including committee service, emergency call, care for unassigned patients and mentoring of new members of the Medical Staff during the provisional period;
- (b) Active participation in the peer review and performance/quality improvement process;

- (c) Inpatient consultations when requested, consistent with the member's privileges and on-call coverage obligations;
- (d) Compliance with applicable attendance requirements for staff, department, and committee meetings; and
- (e) Payment of application fess and dues, if applicable. (6-30-05)

Article II-Part B:
Associate Staff
Section 1. Qualifications:

The Associate Staff shall consist of physicians, dentists, and podiatrists who do not meet one or more of the qualifications for Active Staff appointment but who wish to treat patients at the hospital.

Article II- Part B
Section 2. Prerogatives:

Appointment to the Associate Staff shall carry with it the following prerogatives, subject to other provisions of these bylaws and the Procedural Policy:

- (a) Serving on Medical Staff Committees; and
- (b) Admit and treat patients at the hospital within the scope of their delineated clinical privileges.

Article II- Part B:
Section 3. Responsibilities:

Appointment to the Active Staff shall carry with it the following responsibilities:

- (a) All the responsibilities of membership on the Active Staff, as assigned, including committee service, emergency call, care for unassigned patients and mentoring of new members of the Medical Staff during the provisional period;
- (b) Active participation in the peer review and performance/quality improvement process;
- (c) Inpatient consultations when requested, consistent with the member's privileges and on-call coverage obligations;
- (d) Compliance with applicable attendance requirements for staff, department, and committee meetings; and
- (e) Payment of application fess and dues, if applicable. (6-30-05)

**Article II Part C:
Consulting Staff
Section 1. Qualifications:**

The Consulting Staff shall consist of physicians, dentists, and podiatrists who do not meet one or more of the qualifications for Active Staff appointment but who wish to provide consultations regarding patients at the hospital.

**Article II- Part C:
Section 2. Prerogatives:**

Appointment to the Consulting Staff shall carry with it the prerogatives of providing consultations regarding patients at the hospital within the scope of their delineated clinical privileges subject to other provisions of these bylaws and the Procedural Policy.

**Article II- Part C:
Consulting Staff:
Section 1. Qualifications:**

The Consulting Staff shall consist of those members who:

- (a) Are of recognized professional ability and expertise who provide a service not otherwise available on the Active or Associate Staff;
- (b) Provide services at the Hospital only at the request of other members of the Active or Associate Medical Staff; and
- (c) Are members in good standing of the Active Staff at another hospital where they are currently practicing unless an exception is made by the Medical Executive Committee for physicians practicing in a specialty that has a limited hospital practice.(6-30-05)

**Article II- Part C:
Consulting Staff:
Section 2. Prerogatives and Responsibilities:**

- (a) May treat (but not admit) patients in conjunction with another physician on the Active or Associate Staff; members of the Consulting Staff are not permitted to perform invasive diagnostic or surgical procedures, either on inpatients or outpatients, unless exceptions are granted by the Board of Directors of Freeman Health System. Examples of such exceptions might include, if the Consulting Staff member is the only provider of the service on the Staff or such other compelling reasons that in their discretion the Board of Directors may provide.

- (b) May attend meetings of the Medical Staff (without vote) and applicable department, section, and committee meetings (with vote);
- (c) Must pay application fees and due, if applicable. (6-30-05)

Article II – Part D: Emeritus Staff

Active Staff appointees who have retired from practice shall automatically become members of the Emeritus Staff. They shall not exercise clinical privileges or any prerogatives.

ARTICLE II - PART A: QUALIFICATIONS FOR APPOINTMENT

Section 1. General:

- (a) Appointment to the Medical Staff is a privilege which shall be extended only to professionally competent individuals who continuously meet the qualifications, standards and requirements set forth in this policy and in such policies as are adopted from time to time by the Board. All individuals practicing medicine, dentistry and podiatry in this hospital, unless excepted by specific provisions of this policy, must first have been appointed to the Medical Staff.
- (b) All processes described in this Article shall be subject to the confidentiality provisions described in Article III, Part G of this policy.

ARTICLE II - PART A:

Section 2. Specific Qualifications:

Only physicians and dentists and podiatrists who satisfy the following threshold conditions as determined by the pre-application process described in this policy shall be qualified for appointment to the Medical Staff:

- (a) are currently licensed to practice in this state;
- (b) are located (office and residence) within the geographic service area of the hospital identified as the practitioner's primary site, as defined by the Board, close enough to provide timely and continuous care for their patients; (12-17-98)
- (c) possess current, valid professional liability insurance coverage in such form and in amounts satisfactory to the hospital;
- (d) are certified by the appropriate specialty Board of the American Board of Medical Specialties or the appropriate specialty Board of the American Osteopathic Association ("AOA"), unless such requirement is waived by the Board after considering the specific competence and experience of the individual in question;
- (e) have successfully completed an accredited residency training program, of at least three (3) years, approved by either the Accreditation Council for Graduate Medical Education ("ACGME"), American Osteopathic Association ("AOA"), American Podiatric Association ("APA"), or American Dental Association ("ADA") in the specialty in which the applicant seeks clinical privileges (this qualification shall not apply to individuals who have been appointed to the Medical Staff prior to the Effective Date of this Policy or to practitioners who completed their postgraduate training prior to January 1, 1986);
- (f) can document their:
 - (1) background, experience, training and demonstrated competence;
 - (2) adherence to the ethics of their profession;
 - (3) good reputation and character, including the ability to perform the clinical privileges requested safely and competently; and
 - (4) ability to work harmoniously with others sufficiently to convince the hospital that all patients treated by them at the hospital will receive quality care and that the hospital and its Medical Staff will

- (5) be able to operate in an orderly manner; and
have never been convicted of a felony, or of a misdemeanor related to the practice of their profession, controlled substances, or Medicare, Medicaid or insurance fraud or abuse.

ARTICLE II - PART A:

Section 3. No Entitlement to Appointment:

No individual shall be entitled to appointment to the Medical Staff or to the exercise of particular clinical privileges in the hospital merely by virtue of the fact that such individual:

- (a) is licensed to practice a profession in this or any other state;
- (b) is a member of any particular professional organization;
- (c) has had in the past, or currently has, Medical Staff appointment or privileges at any hospital or health care facility;
- (d) resides in the geographic service area of the hospital as defined by the Board; or
- (e) is affiliated with, or under contract to, any managed care plan, insurance plan, HMO, PPO, or other entity.

ARTICLE II - PART A:

Section 4. Non-Discrimination Policy:

No individual shall be denied appointment on the basis of sex, race, creed, religion, color or national origin, or on the basis of any criteria unrelated to the delivery of quality patient care at the hospital, to professional qualifications or to the hospital's purposes, needs and capabilities.

EXHIBIT B



Cohen, Melissa <melissa.cohen@ppfa.org>

Fwd: application request

1 message

Eisenberg, David [REDACTED]
To: Melissa Cohen <melissa.cohen@ppfa.org>

Fri, Oct 14, 2016 at 8:17 PM

See below/attached

David L. Eisenberg, MD, MPH, FACOG
Associate Professor
Department of Obstetrics & Gynecology
[REDACTED]
Washington University in St. Louis School of Medicine
[REDACTED]
St. Louis, MO 63130
[REDACTED]

Begin forwarded message:

From: "[REDACTED]@Mercy.Net">
To: "Eisenberg, David" [REDACTED]
Subject: RE: application request

Hey Dr Eisenberg, here is a copy of our Bylaws.

Our Verification/credentialing comes out of a Central Verification Office and the form I sent you is for all locations

Within our area.

You will have to work with Springfield separately from Joplin.

Please let me know if there is anything else you need from me.

Thanks and have a great weekend

[REDACTED]

[REDACTED]

Medical Staff Coordinator***Mercy Hospital Joplin, Carthage and Columbus***

Case 2:16-cv-04313-HFS Document 42-1 Filed 01/31/17 Page 34 of 283

100 Mercy Way
Joplin MO 64804

[REDACTED]

From: Eisenberg, David [REDACTED]
Sent: Friday, October 14, 2016 10:56 AM
To: [REDACTED]
Subject: RE: application request

Thank you for the followup. No need to apologize for taking a while to answer. This morning is the first chance I've had to follow up as well.

Would it be possible to share the bylaws and/or credentialing manual with me before I go ahead and initiate the actual application process? It would be helpful to understand the requirements and what categories of privileges are available at the outset as I don't want to spend a lot of both our energies if it seems my ability to work in Joplin will fit the hospital's bylaws.

Also, I am wondering if you handle privileging for the Mercy location in Springfield, MO? I had separately reached out to someone there for information, but have not heard back, and I noticed that the application request document you sent lists both the Joplin and Springfield locations. So I'm not sure if I would have to work with Springfield separately or if I can work with you as to both locations. Can you please clarify?

Thanks again,

David L. Eisenberg, MD, MPH, FACOG
Medical Director
Planned Parenthood of the St. Louis Region and Southwest Missouri
&
Associate Professor
Washington University in St. Louis School of Medicine
Department of Obstetrics & Gynecology

[REDACTED]
St. Louis, MO 63110
[REDACTED]

From: [REDACTED]@Mercy.Net]
Sent: Thursday, September 22, 2016 3:19 PM
To: [REDACTED]
Subject: application request

Case 2:16-cv-04313-HFS Document 42-1 Filed 01/31/17 Page 35 of 283

Good afternoon, first I must apologize for taking so long to get back to you both.

It has been a busy time around here

Attached you will find an application request if you would complete one for each of the providers you are wanting to

get privileged and send the application and a copy of their CV back to me... I will get the process started.

Just so you will understand our process.

You will receive an Email from our Central Verification Office with a link called App Central. The applicant will have to click into the link and complete

All that is requested.

Once your completed application is received back at our CVO it may take up to 6 weeks to acquire all of the verifications necessary

Please call me if you have any questions

Have a great evening [REDACTED]

[REDACTED]
Medical Staff Coordinator

Mercy Hospital Joplin, Carthage and Columbus

100 Mercy Way

Joplin MO 64804
[REDACTED]

This electronic mail and any attached documents are intended solely for the named addressee(s) and contain confidential information. If you are not an addressee, or responsible for delivering this email to an addressee, you have received this email in error and are notified that reading, copying, or disclosing this email is prohibited. If you received this email in error, immediately reply to the sender and delete the message completely from your computer system.

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2 attachments

 **1 - Complete Bylaws Rules and Regs Approved 05112016.pdf**
1026K

 **ATT00001.htm**
1K



MERCY HOSPITAL JOPLIN

MEDICAL STAFF BYLAWS

PART I: MEDICAL STAFF GOVERNANCE

February 6, 2015

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Section 1. Definitions

The following terms shall have the meanings as set forth below, unless the context clearly indicates otherwise. Any definitions set forth in the Medical Staff Bylaws shall also apply to terms used in Medical Staff Rules and Regulations and policies/procedures.

Administration

Administration is the executive members of the Hospital staff, including the Chief Executive Officer (CEO/President), Chief Operating Officer (COO), Chief Financial Officer (CFO), Chief Nursing Officer (CNO) and Vice Presidents.

Advanced Practice Professionals (APP)

Advanced Practice Professional's are individuals, other than those defined under "Licensed Independent Practitioner/Practitioner", who hold a license, certificate, or other legal credential as required by state law that authorizes the provision of complex, clinical services to patients, while working collaboratively with a member of the Medical Staff. APPs must provide safe patient care, treatment and services under the terms and conditions recognized by the Medical Staff Bylaws, Rules and Regulations and Policies/Procedures. APPs are credentialed through Medical Staff Services and are granted clinical privileges as dependent healthcare professionals as defined in these Bylaws. APPs are not eligible for Medical Staff membership. The Board has determined the categories of individuals eligible for clinical privileges as an APP are physician assistants (PA), certified registered nurse anesthetists (CRNA), clinical psychologists (PhD, PsyD), and advanced registered nurse practitioners (ARNP).

Adverse Action

An adverse action is an event/occurrence that has a negative effect on an individual's Medical Staff membership and/or clinical privileges. An adverse action shall entitle the individual to the procedural rights set forth in Part II (Investigations, Corrective Action, Hearing and Appeal Plan) of these Bylaws. An adverse action shall include a denial and/or termination of Medical Staff membership, and/or a denial, reduction, and/or termination of clinical privileges.

Allied Health Professional (AHP)

Allied Health Professionals are individuals who are permitted both by law and by the Hospital to provide patient care services under the direction and/or supervision of an independent practitioner, within the scope of the individual's license and in accordance with a Hospital approved scope of practice.

Applicant

An applicant is an individual who has submitted a completed application for appointment, reappointment and/or clinical privileges.

Board Certification or Board Certified

A designation for a physician or other practitioner who has completed an approved educational training program and an evaluation process including an examination designated to assess the knowledge, skills, and experience necessary to provide quality patient care in that specialty. The physician/practitioner maintains certification through retesting and completion of maintenance of certification requirements. Physicians' board certification shall be from a Member Board of American Board of Medical Specialties (ABMS) or from a Member Board of Certification of the Bureau of Osteopathic Specialists. Oral surgeons' board certification shall be from the American Board of Oral/Maxillofacial Surgeons (ABOMS). Podiatrists are certified through the American Board of Podiatric Surgery (ABPS). Member boards determine whether candidates have received appropriate preparation in approved residency training programs in accordance with established educational standards, evaluate candidates with comprehensive examinations, and certify those candidates who have satisfied the board requirements.

Board Certification Candidate

A board certification candidate is an individual who has successfully completed a residency or fellowship program for his or her specialty within the last five (5) years and who is able to provide proof that he or she has applied for and been accepted to take the exam for certification, or has successfully completed the written portion of the exam and is a current candidate to take an oral portion of the testing, or submit cases for review, or otherwise complete the certification requirements. A practitioner shall no longer be deemed a board certification candidate if the five (5) year time limit has been exceeded without successful completion of board certification and/or the practitioner has exhausted the permitted number of attempts at the exam without success.

Board of Directors/Governing Body

The local governing body of the Hospital who has been delegated specific authority and who holds ultimate responsibility for the Hospital and is herein referred to as the "Board".

Certification

The procedure and action by which a duly authorized body evaluates and recognizes (certifies) an individual as meeting predetermined requirements.

Chief of Staff

A Member of the active Medical Staff who is elected in accordance with these Bylaws to serve as Chief Officer of the Medical Staff of this Hospital. The Chief of Staff shall be a doctor of medicine or osteopathy.

Clinical Privilege/Privilege

Clinical privilege/privilege is the permission granted by the Board to appropriately licensed individuals to render specifically delineated professional, diagnostic, therapeutic, medical, surgical, psychological, dental, or podiatry services.

Clinical Service

A Clinical Service is a sub-grouping of members of a Medical Staff Department in accordance with their subspecialty or specialized practice interest. A Clinical Service must be formally recognized by the Hospital's Medical Executive Committee (MEC).

Complete Application

A complete application is an application for either initial appointment or reappointment to the Medical Staff, or an application for clinical privileges, that has been determined by the applicable Medical Staff Department Chair, the Credentials Committee, the MEC and/or the Board to meet the requirements of these Bylaws. Specifically, to be complete, the application must be submitted in writing on a form approved by the MEC and the Board, and include all required supporting documentation and verification of information, and any additional information needed to perform the required review of qualifications and competence for each of the privileges requested and proof that the applicant meets the criteria for each of the privileges requested.

Conflict Management

Conflict management is the identification and use of techniques to effectively manage interpersonal, intra- and inter-group, and organizational conflicts. It requires impartiality and use of negotiating and listening skills.

Contract Practitioner

A contract practitioner is a practitioner providing care or services to hospital patients through a contract or other arrangement.

Credentials Procedure Manual (CPM)

The Credentials Procedure Manual is Part III of the Medical Staff Bylaws of Mercy Hospital Joplin and enumerates the qualifications for membership and granting of clinical privileges, applicable to the initial and reapplication process.

Criminal Action

A conviction, or a plea of guilty or no contest pertaining to any felony, or to any misdemeanor involving (i) controlled substances; (ii) illegal drugs; (iii) Medicare, Medicaid, insurance or health care fraud or abuse; or (iv) violence against another.

Days

Calendar days, unless otherwise noted.

Dentist

A dentist is a practitioner who has received a doctor of dental surgery or a doctor of dental medicine degree from a dentistry (dental) program accredited by the Commission on Dental Accreditation and has a current valid license to practice dentistry in the state.

Department

A department is a clinical grouping of members of the Medical Staff in accordance with their specialty or major practice interest, as specified in these Bylaws. Departments must be formally recognized by the Hospital's MEC.

EPIC (Electronic Medical Record)

The EPIC system is used to electronically document patient care in the hospital.

Ex Officio

Ex officio is an individual who is a member of a committee or body by virtue of an office or position held, and unless otherwise expressly provided, has no voting rights.

Federal Health Care Program:

Any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded directly, in whole or in part, by the United States Government or a State health care program (with the exception of the Federal Employees Health Benefits Program). The most significant Federal health care programs are Medicare, Medicaid, Blue Cross Federal Employee Program (FEP)/Tricare and the Veterans programs.

General Services Administration (GSA):

The General Service Administration's single comprehensive list of individuals and firms excluded by Federal government agencies from receiving federal contracts or federally approved subcontracts and from certain types of federal financial and nonfinancial assistance and benefits, also known as the Excluded Parties List System (EPLS).

Good Standing

The term "good standing" refers to a Medical Staff member who during the current term of appointment has maintained all qualifications for Medical Staff membership and been granted clinical privileges; has met on-call and other participation requirements; is not in arrears in completion of medical records; and has not received a limitation, suspension or restriction of Medical Staff membership or clinical privileges.

Hospital

The Hospital is Mercy Hospital Joplin. As the term is used in these Bylaws, it shall mean all of the facilities, services, and locations licensed or accredited as part of the Hospital, inclusive of the Medical Staff.

Ineligible Person

Any individual who: (1) is currently excluded, suspended, debarred or otherwise ineligible to participate in Federal health care programs; or (2) has been convicted of a criminal offense related to the provisions of health care items or services but has not yet been excluded, debarred, or otherwise declared ineligible or (3) is currently on a state exclusion list.

Investigation

An investigation means a process specifically initiated by the MEC to determine the validity, if any, to a concern or complaint brought against a member of the Medical Staff.

Investigations, Corrective Action, Hearing and Appeal Plan

Investigations, Corrective Action, Hearing and Appeal Plan is outlined in Part II of the Medical Staff Bylaws of Mercy Hospital Joplin and enumerates the fair hearing and appeal plan for Medical Staff members.

License/Licensure

A license is an official or legal permission, granted by a competent authority, usually public, to an individual to engage in a practice, an occupation, or an activity otherwise unlawful.

Licensed Independent Practitioner/Practitioner (LIP)

Licensed Independent Practitioner/Practitioner is an individual who is permitted by both State law and by the Hospital to provide patient care services; within the scope of the individual's license; and in accordance with individually granted clinical privileges. These are practitioners who are designated by the State and the Hospital to provide independent patient care. The Board has determined that the categories of the practitioners eligible for clinical privileges as an LIP are physicians (MD or DO), maxillofacial/oral surgeons (DDS/DMD), dentists (DDS/DMD), and podiatrists (DPM).

Medical Executive Committee (MEC)

The Medical Executive Committee (MEC) shall mean the medical executive committee of the Hospital Medical Staff and includes at least the Chief of Staff, the Vice Chief of Staff and the Hospital CEO/President.

Medical Staff

The Medical Staff is the term referring to the practitioners designated by the Hospital to be eligible for Medical Staff membership and who are credentialed and privileged to provide professional healthcare services. The Board has determined that the categories of practitioners eligible for Medical Staff membership are physicians (MD or DO), maxillofacial/oral surgeons (DDS/DMD), dentists (DDS/DMD), and podiatrists (DPM). The Medical Staff is an integral part of the Hospital and is not a separate legal entity.

Medical Staff, Organized

The organized Medical Staff is the body of those practitioners who, as a group, are responsible for establishing the Medical Staff Bylaws, Rules and Regulations and the policies/procedures for the Medical Staff at large and for overseeing the quality of care provided by all Medical Staff members. The organized Medical Staff is limited to practitioners who are Medical Staff members of the Active category and therefore have been granted the right to vote, serve as a member of Medical Staff committee, and to hold office in the organized Medical Staff.

Medical Staff Bylaws (Bylaws)

The Medical Staff Bylaws shall mean a document or group of documents adopted by the voting members of Mercy Hospital Joplin Medical Staff and approved by the Board. Medical Staff Bylaws defines the rights, responsibilities, and accountabilities of the Medical Staff and various officers, persons, and groups within the structure of the Medical Staff; the self governance functions of the Medical Staff; and the working relationship with and accountability to the governing body (Board) of the Hospital.

Medical Staff Services

Medical Staff Services is the Hospital co-worker(s) or contractor assigned the responsibility for processing applications for Medical Staff appointments, reappointments, requests for clinical privileges, and for maintaining documents related to the credentialing process. Medical Staff Services responsibilities are assigned by Administration. The Hospital co-workers/contractors who work in Medical Staff Services are accountable to Administration. The documents maintained by Medical Staff Services are the property of the Hospital.

Medical Staff Year

The Medical Staff Year is the period from January 1 to December 31 of each calendar year.

Medico-Administrative Practitioner

A practitioner who is under contract, employed by, or otherwise engaged by the Hospital on a full time or part time basis, whose responsibilities may be both administrative and, if permitted by State laws, clinical in nature. Clinical duties may relate to direct medical care of patients and/or supervision of the professional activities of individuals under such practitioner's direction.

Member

A practitioner who has been granted and maintains Medical Staff membership and whose membership is in good standing pursuant to these Bylaws.

Membership

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

Mercy Health (Mercy)

Mercy Health is the parent organization and includes all hospitals and facilities within the organization and herein referred to as "Mercy".

Oral and maxillofacial Surgeon

An oral and maxillofacial surgeon is a practitioner who has successfully completed a postgraduate program in oral and maxillofacial surgery accredited by the Commission on Dental Accreditation and who is legally authorized to practice by the State in which he or she performs such function or action. Clinical Services which are approved by the MEC and the Board are also included in the Manual,

Organization and Functions Manual

The Organization and Functions Manual is Part IV of the Medical Staff Bylaws of Mercy Hospital Joplin and outlines the responsibilities and functions of officers and committees. Clinical Services which are approved by the MEC and the Board are also included in this Manual.

Peer

A peer is an individual from the same discipline (physician and physician, dentist and dentist) with essentially equal qualifications.

Peer Review

The concurrent or retrospective review of an individual's performance of clinical professional activities by peer(s) through formally adopted written procedures. These procedures provide for adequate notice and an opportunity for a hearing of the individual under review.

Physician

A physician is a practitioner who has received a doctor of medicine or doctor of osteopathy degree and who is legally authorized to practice medicine and/or surgery by the State in which he or she performs such function or action.

Podiatrist

A podiatrist is a practitioner who has received the degree of doctor of podiatric medicine and who is licensed to practice podiatry by the State in which he or she performs such function or action.

Prerogative

A prerogative is the participatory rights granted by virtue of Staff category to a Medical Staff member, which are exercisable subject to, and in accordance with, the conditions imposed by these Medical Staff Bylaws.

Privileges

Privileges is the authorization granted by the Board to an individual to provide specific patient care services in the Hospital based on the individual's license, education, training, experience, competence, health status, judgment, individual character and performance. Privileges shall be setting specific, meaning that the privileges granted shall be based not only on the applicant's qualifications, but also a consideration of the Hospital's capacity and capability to deliver care, treatment and services within a specified setting.

Proctor/Proctoring

Clinical proctoring is an objective evaluation of an individual's actual clinical competence by a monitor or proctor who represents the Medical Staff and is responsible to the Medical Staff.

Rules and Regulations

Rules and Regulations may contain associated details for provision in the Medical Staff Bylaws. "Associated Details" are the procedural steps necessary to describe, implement, enforce, or otherwise operationalize the provisions of the Bylaws.

Staff

Unless otherwise specifically stated, refers to the Medical Staff of the Hospital.

State

The State in which the Hospital operates and is licensed to provide patient care services, which is Missouri.

Telemedicine

Telemedicine is defined as any contact that results in a written or documented medical opinion that affects the medical diagnosis and/or medical treatment of a patient. Telemedicine is the practice of medicine through the use of electronic communication and/or other communication technologies to provide and/or support clinical care at a distance. The Joint Commission and the American Telemedicine Association define telemedicine as the use of medical information exchanged from one site to another via electronic communications for the health and education of the patient or healthcare provider and for the purpose of improving patient care, treatment and services.

Unprofessional or Inappropriate Conduct:

Unprofessional or Inappropriate Conduct shall mean any conduct which adversely impacts the operation of the Hospital, affects the ability of others to get their jobs done, creates a hostile work environment for Hospital co-workers or other individuals working in the Hospital or begins to interfere with the individual's own ability to practice competently. Such conduct may include disruptive, rude or abusive behavior or comments to staff members or patients; negative comments to patients about other physicians, nurses or co-workers, and/or their treatment in the Hospital; threats and/or physical assaults; sexual harassment; refusal to accept Medical Staff assignments; disruption of committee or departmental affairs; and/or inappropriate comments written in patient medical records and/or other official documents.

Section 2. Purpose and Responsibilities of Medical Staff Membership

2.1 Name

The name of the Medical Staff shall be the "Medical Staff of Mercy Hospital Joplin"

2.2 Purposes and Responsibilities

The purposes and responsibilities of the Medical Staff are:

- 2.2.1 To provide a formal organizational structure through which the Medical Staff shall carry out its responsibilities and govern the professional activities of its members and other individuals with clinical privileges, and to provide mechanisms for accountability of the Medical Staff to the Board. These Bylaws shall reflect the current organization and functions of the Medical Staff;
- 2.2.2 To provide patients with the quality of care that is commensurate with acceptable standards and available community resources;
- 2.2.3 To collaborate with the Hospital in providing the uniform performance of patient care processes throughout the Hospital;
- 2.2.4 To serve as a primary means for accountability to the Board concerning professional performance of Practitioners and others with clinical privileges authorized to practice at the hospital with regard to the quality and appropriateness of health care. This shall be provided through leadership and participation in the quality assessment, performance improvement, risk management, case management, utilization review and resource management, and other Hospital initiatives to measure and improve performance;
- 2.2.5 To provide mechanisms for recommending to the Board the appointment and reappointment of qualified Practitioners, and making recommendations regarding clinical privileges for qualified and competent Healthcare Professionals;
- 2.2.6 To provide education that will assist in maintaining patient care standards and encourage continuous advancement in professional knowledge and skills;
- 2.2.7 To adopt Rules and Regulations for the proper functioning of the Medical Staff, and the integration and coordination of the Medical Staff with the functions of the Hospital;

- 2.2.8 To provide a means of communication and conflict management with regards to issues of mutual concern to the Medical Staff, Administration and Board;
- 2.2.9 To participate in identifying community health needs and establishing appropriate institutional goals;
- 2.2.10 To provide mechanisms for recommending to the Board the appointment and reappointment of qualified practitioners and making recommendations regarding clinical privileges for qualified and competent Advanced Practice Professionals (APP);
- 2.2.11 To assist the Board by serving as a professional review body in conduction professional review activities, which include, without limitation, focused professional practice evaluation, ongoing professional practice evaluation quality assessment, performance improvement and peer review;
- 2.2.12. To pursue corrective action with respect to members of the Medical Staff or those individuals granted clinical privileges, when warranted: and
- 2.2.13 To maintain compliance of the Medical Staff with regards to applicable accreditation requirements and applicable Federal, State and local laws and regulation;
- 2.2.14 To monitor and enforce compliance with these Bylaws, Rules and Regulations, and Hospital policies/procedures.

2.3 Nature of Medical Staff Membership

Membership on the Medical Staff of Mercy Hospital Joplin is a privilege that shall be extended only to professionally competent practitioners who continuously meet the qualifications, standards, and requirements set forth in these Bylaws and associated policies/procedures of the Medical Staff and Mercy Hospital Joplin.

2.4 Qualifications for Medical Staff Membership

Qualifications for membership are delineated in the Credentials Procedure Manual, Part III, Section 2.

2.5 Nondiscrimination

The Hospital will not discriminate in granting Medical 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.

2.6 Conditions and Duration of Appointment

The Board shall approve the initial appointment and reappointment to the Medical Staff for those practitioners requesting clinical privileges. The Board shall act on appointment and reappointment only after there has been a recommendation for such appointment/reappointment from the Hospital's Medical Executive Committee (MEC). Initial appointment to the Medical Staff shall be for a period of no more than twenty-four (24) calendar months. Thereafter, reappointment to the Medical Staff shall be for a period of no more than twenty-four (24) calendar months.

2.7 Medical Staff Membership and/or Clinical Privileges

Requests for Medical Staff membership and/or clinical privileges will be processed only when the potential applicant meets the current minimum threshold criteria recommended by the MEC and approved by the Board. In the event there is a request for privileges for which there are no approved criteria, the Board, with input from the MEC and Administration, will determine if it will allow the privilege and, if so, direct the MEC to develop privileging criteria based on licensure, relevant training and/or experience, current competence and the ability to perform the privileges requested.

2.8 Medical Staff Member Responsibilities

- 2.8.1 Each Medical Staff member must provide appropriate, timely, and continuous care of his or her patients. He or she is not responsible for the actions of other practitioners, advanced practice professionals, allied health practitioners (unless under his or her supervision), or hospital employees, unless such responsibility is imposed upon a member of the Medical Staff by contract.
- 2.8.2 Each Medical Staff member must participate, as assigned or requested, in quality/performance improvement/peer review activities and in discharging other Medical Staff functions as required.
- 2.8.3 Each Medical Staff member, consistent with his or her granted clinical privileges, must participate in the on call coverage of the emergency department and/or in other Hospital coverage programs, including consultations for inpatients as determined by the MEC and the Board, and after receiving input from the appropriate clinical specialty, to assist in meeting the patient care needs of the community.
- 2.8.4 Each Medical Staff member must submit to any type of health evaluation as requested by the MEC, CEO/President (or designee) when it appears necessary to protect the well-being of patients and/or staff, or when requested by the Credentials Committee as part of an evaluation of the members ability to exercise privileges safely and competently or as part of a post-treatment monitoring plan consistent with the provisions of Medical Staff and Hospital policies/procedures addressing physician health or impairment.
- 2.8.5 Each Medical Staff member must abide by the Medical Staff Bylaws, the Rules and Regulations, Hospital policies/procedures, and standards, including its policies/procedures on professional conduct and behavior.
- 2.8.6 Each Medical Staff member must provide evidence of professional liability coverage of a type and in an amount established by the Board. In addition, Medical Staff members shall comply with any financial responsibility requirements that apply under state law to the practice of their profession. Each Medical Staff member shall notify the CEO/President (or designee) immediately of any and all malpractice claims in writing or filed against the Medical Staff member.
- 2.8.7 Each Medical Staff member 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 provided by the Medical Staff member and his or her credentials.
- 2.8.8 Each Medical Staff member shall prepare and complete in timely fashion, according to Medical Staff and Hospital policies/procedures, 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.

- 2.8.9 Each Medical Staff member will use confidential information only as necessary for treatment, payment or healthcare operations in accordance with Health Insurance Portability and Accountability Act (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.
- 2.8.10 Each Medical Staff member 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.
- 2.8.11 Each Medical Staff member must utilize the Hospital and related facilities consistent with the *Ethical and Religious Directives for Catholic Health Facilities*.
- 2.8.12 Each Medical Staff leader shall disclose to the Medical Staff any ownership or financial interest that may conflict, or have the appearance of conflicting with, the interest of the Medical Staff or Hospital. Medical Staff leadership will address conflict of interest issues per Section 8.

2.9 Medical Staff Member Rights

- 2.9.1 Each Medical Staff member 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 or 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.
- 2.9.2 Each Medical Staff member in the Active category has the right to initiate a recall election of a Medical Staff officer by following the procedure outlined in Section 4.7 of these Bylaws, regarding removal and resignation from office.
- 2.9.3 Each Medical Staff member in the Active category may initiate a call for a general staff meeting to discuss a matter relevant to the Medical Staff. Upon presentation of a petition signed by twenty-five percent (25%) of the members of the Active category, 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.
- 2.9.4 Each Medical Staff member in the Active category may challenge any Rule and Regulation or policy established by the MEC. In the event that a Rule and Regulation or policy is thought to be inappropriate, any Medical Staff member may submit a petition signed by twenty-five percent (25%) of the members of the Active category. Upon presentation of such a petition, the adoption procedure outlined in Section 10.3 will be followed.
- 2.9.5 Each Medical Staff member in the Active category may call his or her department meeting by presenting a petition signed by twenty-five percent (25%) of the department. Upon presentation of such a petition the Department Chair will schedule a department meeting.

- 2.9.6 Any Officer of the Medical Staff may request and be granted a meeting with the CEO/President, or the Board to discuss any important issue or conflict at an agreed upon date, place, and time.
- 2.9.7 The above Sections 2.9.1-2.9.3 do not pertain to issues involving professional review action, denial of requests for appointment or clinical privileges, or any other matter relating to individual membership or privileging sections. Part II of these Bylaws (Investigations, Corrective Action, Hearing and Appeal Plan) provides recourse in these matters.
- 2.9.8 Any Medical Staff member has a right to a fair hearing/appeal pursuant to the conditions and procedures described in Part II of these Bylaws (Investigations, Corrective Action, Hearing and Appeal Plan).

2.10 Medical Staff Fees/Dues

- 2.10.1 Initial application fees shall be determined by the MEC and collected in the form of a nonrefundable fee.
- 2.10.2 Annual Medical Staff dues shall be determined by the MEC and collected in the form of a nonrefundable payment.
- 2.10.3 Failure to pay dues within ninety (90) days of assessment shall be construed as a voluntary resignation from the Medical Staff.

2.11 Indemnifications

- 2.11.1 Members of the Medical Staff are entitled to the applicable immunity provisions of state and federal law for credentialing, peer review, and performance improvement work he or she performs on behalf of the hospital and Medical Staff.
- 2.11.2 Subject to applicable law, the Hospital shall indemnify against actual and necessary expenses, cost, 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 or she is made party by reason of his or her having acted in an official capacity in good faith on behalf of the Hospital or Medical Staff. However no Medical Staff member shall be entitled to such indemnification if the acts give rise to liability constituted as willful misconduct, breach of a fiduciary duty, self-dealing or bad faith.

Section 3. Categories of the Medical Staff

3.1 The Active Category

3.1.1 Qualifications

Appointees to this category must have first served on the Medical Staff as an Associate member for one (1) year and must be involved in patient contacts (i.e. a patient contact is defined as an inpatient admission, consultation, or outpatient surgical procedure) at the Hospital during the most recent two (2) year period.

In the event that an appointee to the Active category does not meet the qualifications for reappointment to the Active category, and if the appointee is otherwise abiding by all Medical

Staff Bylaws, the Rules and Regulations, and the Hospital Policy Manual, and other policies/procedures, the appointee may be appointed to another Medical Staff category if he or she meets the eligibility requirements for such category.

3.1.2 Prerogatives

Members of this category may:

- a. Exercise such clinical privileges as are recommended by the MEC and granted by the Board;
- b. Attend Medical Staff, department and clinical service meetings of which he or she is a member and any Medical Staff, Hospital or Mercy education programs;
- c. Vote on all matters presented by the Medical Staff by the appropriate Clinical Service and/or the committee of which he or she is a member; and
- d. Hold office and sit or chair any committee in accordance with qualifying criteria set forth elsewhere in these Bylaws or Medical Staff policies/procedures.

3.1.3 Responsibilities

Members of this category shall:

- a. Contribute to the organizational and administrative affairs of the Medical Staff and Hospital;
- b. Actively participate as requested or required in activities and in functions of the Medical Staff including quality, performance improvement, peer review, risk and utilization management, medical records completion, monitoring of new appointees and in discharging other Medical Staff functions as may be required;
- c. Fulfill or comply with Medical Staff and Hospital policies/procedures; and
- d. Attend Hospital staff meetings and fulfill any meeting attendance requirements as established by the Medical Staff.

3.2 The Associate Category

3.2.1 Qualifications

The Associate category is reserved for Medical Staff members who do not meet the eligibility requirements for the Active category or choose not to pursue Active category membership.

3.2.2 Prerogatives

Members of this category may:

- a. Exercise such clinical privileges as are recommended by the MEC and granted by the Board;
- b. Attend Medical Staff, department and clinical service meetings of which he or she is a member and any Medical Staff, Hospital or Mercy education programs;
- c. Serve on Medical Staff committees, other than the MEC, as an ex-officio member; and
- d. Not vote on matters before the entire Medical Staff or be an officer of the Medical Staff.

3.2.3 Responsibilities

Members of this category shall:

- a. Have the same responsibilities as Active category Medical Staff members.

3.3 The Affiliate Category

3.3.1 Qualifications

The Affiliate category shall include those Medical Staff members who are not actively involved in Medical Staff functions and are not major contributors to fulfillment of Medical Staff functions, due to practicing primarily at another hospital or in an office-based specialty, or other reasons, but who wish to remain affiliated with the Hospital for referral of patients, or other patient care purposes.

3.3.2 Prerogatives

Members of this category may:

- a. Exercise only "Refer and Follow" privileges as are recommended by the MEC and granted by the Board;
- b. Not vote or hold office within the Medical Staff organization; and
- c. Not serve on committees
- d. Not attend department meetings but may attend Annual and Semi-Annual Medical Staff meetings as a nonvoting member.

3.3.3 Responsibilities

Members of this category shall:

- a. Fulfill or comply with Medical Staff and Hospital policies/procedures.

3.4 The Telemedicine Category

3.4.1 Qualifications

The Telemedicine category includes those practitioners who provide telemedicine services and satisfy the basic qualification for clinical privileges. Telemedicine practitioners are not considered Medical Staff members but are subject to all requirements as stated in Medical Staff Bylaws.

3.4.2 Prerogatives

Members of this category may:

- a. Exercise such clinical privileges as are recommended by the MEC and granted by the Board;
- b. Not vote or hold office within the Medical Staff organization;
- c. Not attend Medical Staff and department meetings; and
- d. Not serve on committees.

3.4.3 Responsibilities

Members of this category shall:

- a. Fulfill or comply with Medical Staff and Hospital policies/procedures.

3.5 Honorary Status

3.5.1 Qualifications

Honorary status is reserved for practitioners who have retired from active hospital practice and are recognized for their outstanding reputations, and their noteworthy contributions to the Hospital. Such practitioners are presented by the Chief of Staff to the MEC for recommendation to the Board for approval. Appointment to the honorary category is entirely discretionary and may be rescinded at any time. Honorary designees are not considered Medical Staff members and are not subject to reappointment.

- 3.5.2 Honorary designees may attend Medical Staff meetings, and continuing medical education activities.

3.5.3 Limitations

Honorary designees shall not hold clinical privileges, hold office or be eligible to vote.

Section 4. Officers of the Medical Staff

4.1 Officers of the Medical Staff

4.1.1 Chief of Staff

4.1.2 Vice Chief of Staff

4.2 Qualifications of Officers

- 4.2.1 Officers must be members in good standing of the Active category, be actively involved in patient care in the Hospital, indicate a willingness and ability to serve, have no pending adverse recommendations concerning Medical Staff appointment or clinical privileges, have demonstrated an ability to work well with others, and have excellent administrative and communication skills. Qualifications for the positions of Chief of Staff and Vice Chief of Staff include the degrees of MD, or DO.

- 4.2.2 Officers may not simultaneously hold leadership positions in a facility that is directly competing with any Mercy Hospital. Noncompliance with this requirement will result in the Officer being automatically removed from office unless the Board determines that allowing the Officer to maintain his or her position is in the best interest of the Hospital. The Board shall have discretion to determine what constitutes a "leadership position" at another hospital.

4.3 Election of Officers

Every other year, the MEC shall serve as the Nominating Committee and prepare a slate of nominees for its officers to the Board for approval. The slate of nominees will be communicated to the Medical Staff fifteen (15) days prior to its submission to the Board. Additional nominees' names may be added to the slate by a petition signed by fifty percent (50%) or more of the Active Staff Members of the Hospital and delivered to Medical Staff Services before the expiration of the fifteen (15) days. The Nominating Committee must determine if the candidate meets the qualifications in Section 4.2 above before he or she can be placed on the ballot.

The slate of nominees will then be forwarded to the Board. After the Board has approved the slate of nominees, a ballot shall be prepared with a list of the nominees and will be sent electronically to Active Staff members. Ballots shall be returned to Medical Staff Services at a date set by the MEC and will not be less than fifteen (15) days from the date the ballot was sent to the Active Staff members. The plurality of votes cast will determine the individual(s) successfully elected.

4.4 Term of Office

All officers shall serve a term of two (2) years and shall take office on the first day of the odd medical staff year following his or her election. An Officer may be reelected and will not be restricted by any term limits.

4.5 Vacancies of Office

In the event an Officer is absent or the position becomes vacant, the MEC shall designate a physician to assume the duties and responsibilities of the Officer until such time as the Officer returns or shall serve the balance of the term of office of the preceding Officer or until the election process can be carried out to fill the vacancy. Such designated physician must be approved by the Board.

4.6 Duties of Officers

4.6.1 Chief of Staff: The Chief of Staff shall represent the interests of the Medical Staff to the MEC and the Board. The Chief of Staff shall serve on the MEC, and shall perform such further duties to assist the CEO/President and/or Vice Chief of Staff as requested. Chief of Staff's duties are further specified in the Part IV Organization and Functions Manual.

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 serve on the MEC, and shall perform such further duties to assist the CEO/President and/or Chief of Staff as requested. Vice Chief of Staff duties are further specified in the Part IV Organization and Functions Manual.

4.7 Removal and Resignation from Office

4.7.1 The Medical Staff may remove any Officer of the Medical Staff if at least fifty percent (50%) of the Active Medical Staff members of the hospital sign a petition advocating for such action. The petition must be followed by an affirmative vote by two-thirds (2/3) of those Active staff members casting ballot votes.

4.7.2 The CEO/President and the MEC may recommend to the Board removal of an Officer for reasons of unsatisfactory performance and/or failure to maintain the qualifications of the position. Upon receipt of the recommendation, the Board may remove an Officer.

- 4.7.3 Automatic removal shall be for failure to meet those responsibilities assigned within these Bylaws, or other policies/procedures of the Medical Staff, or for conduct or statements damaging to any Mercy Hospital, its goals, or programs, or an automatic or summary suspension of clinical privileges that lasts more than thirty (30) days. The Board will determine if the member has failed in his or her duties after consulting with the MEC.
- 4.7.4 Resignation: An Officer may resign at any time by giving written notice to the MEC. Such resignation, which may or may not be made contingent upon acceptance by the MEC, takes effect on the date of receipt, when his or her 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 as a departmentalized staff to include Primary Care, Surgical Care, Specialty Care and Hospital Based Specialties. A Department Chair shall head each department with overall responsibility for the supervision and satisfactory discharge of assigned functions under the MEC. The Medical Staff may create Clinical Services 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 Part IV of the Bylaws (Organization and Functions Manual).

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

5.2 Qualifications, Selection, Term and Removal of Department Chair

- 5.2.1 Each Department Chair shall serve a term of two (2) years commencing on January 1 of every even year and may be elected to serve successive terms. All chairs must be members of the Active Medical Staff and have been an active member of the department for at least two (2) years, have relevant clinical privileges and be certified by an appropriate specialty board or have affirmatively established comparable competence through the credentialing process.
- 5.2.2 Department Chairs shall be elected by majority vote of the Active category members of the department who vote in the election, subject to ratification by the MEC. Each department shall establish procedures for identifying and electing candidates and these procedures must be ratified by the MEC.
- 5.2.3 Department Chairs may be removed from office by the MEC if two-thirds (2/3) of the voting members of the department recommend such action, or, in absence of such recommendation, the MEC may remove a Chair on its own by two thirds (2/3) vote if any of the following occurs:
- a. The Chair suffers an involuntary loss or significant limitation of practice privileges or fails to maintain qualifications to be Department Chair; or
 - b. The MEC determines the Chair has failed to demonstrate to the satisfaction of the MEC and the Board that he or she is effectively carrying out the responsibilities of the position as assigned in Part IV of these Bylaws (Organization and Functions Manual).

5.2.4 Department Chairs will be removed from office automatically if the following occurs:

- a. The Chair ceases to be a member in good standing of the Medical Staff.

5.2.5 If a Department Chair is removed a new election will be held according to the established departmental procedures.

5.3 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 (1) primary department. Clinical privileges are independent of department assignment.

Section 6. Committees

6.1 Designation and Substitution

There shall be a MEC and such other standing and ad hoc committees as established by the MEC and enumerated in Part IV of these Bylaws (Organization and Functions Manual). 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 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 MEC

6.2.1 Committee Membership

- a. **Composition:**
The MEC shall be a standing committee consisting of at least seven (7) members including the Chief of Staff, Vice Chief of Staff, Department Chairs and Hospital CEO/President. Members of the MEC shall serve a two (2) year term which shall begin on the first day of the calendar year following his or her appointment, and may be reappointed. All members of the MEC shall vote. The Chair will be the Chief of Staff.

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. Submit recommendations to the Board concerning all matters relating to appointment, reappointment, staff category, department/clinical service assignments, clinical privileges, and corrective action;
- c. Report to the Board and to the staff 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;

- d. Coordinate the implementation of policies/procedures adopted by the Board, or the Medical Staff;
- e. Conduct peer review activities in a manner consistent with federal and state laws and oversee the activities of committees that have been delegated peer review activities, including but not limited to clinical care, morbidity and mortality reviews;
- f. Take reasonable steps to encourage professionally ethical conduct and competent clinical performance on the part of the Medical Staff members including collegial and educational efforts and investigations, when warranted;
- g. Make recommendations to the Board on medical administrative and Hospital management matters;
- h. Communicate to the Medical Staff regarding the licensure and accreditation status of the Hospital;
- i. Participate in identifying community health needs and in setting Hospital goals and implementing programs, to meet those needs;
- j. Represent and act on behalf of the Medical Staff, subject to such limitations as may be imposed by these Bylaws;
- k. Review and act on reports from Medical Staff committees, departments, and other assigned activity groups;
- l. Formulate and recommend to the Board, Medical Staff Bylaws, Rules and Regulations and policies/procedures;
- m. Request evaluations of practitioners privileged through the Medical Staff process when there is a question(s) about an applicant or member's ability to perform privileges requested or currently granted;
- n. 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;
- o. Consult with Administration on the quality, timeliness, and appropriateness of contracts for patient care services provided to the Hospital by entities outside the Hospital;
- p. Oversee that portion of the corporate compliance plan that pertains to the Medical Staff;
- q. Hold Medical Staff leaders, committees, and departments/clinical services accountable for fulfilling their duties and responsibilities;
- r. Make recommendations to the Medical Staff for changes or amendments to the Medical Staff Bylaws;
- s. Empowered to act for the organized Medical Staff between meetings of the organized Medical Staff; and
- t. Other duties as are delegated to the MEC by the Board.

6.2.3 Meetings

The MEC shall meet at least once a month or more often as needed to perform their assigned functions. Meetings may be held in person or via electronic means. Permanent records of its proceedings and actions shall be maintained.

6.2.4 Quorum

A majority of the members of the MEC shall constitute a quorum for the transaction of business at any meeting of the MEC.

6.2.5 Confidentiality

All members of the MEC shall, consistent with Medical Staff and Hospital confidentiality policies/procedures, keep in strict confidence all papers, reports, and information obtained by virtue of membership on the committee.

Section 7. Medical Staff Meetings

7.1 Medical Staff Meeting

- 7.1.1 An annual meeting and other general meetings, if any, of the Medical Staff shall be held at a time and manner determined by 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 the meeting of the Medical Staff are the actions of the group. Actions 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 email 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. Such requests or resolution shall state the purpose of the meeting. The Chief of Staff shall designate a 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 what is stated in the notice of such meeting.
- 7.1.4 A quorum is those eligible Medical Staff members who cast a vote on an issue(s), as defined in Section 7.1.2 above.

7.2 Regular Meetings of Medical Staff Committees and Departments

- 7.2.1 Medical Staff committees and departments shall hold meetings as needed to carry out business as specified in Part IV of these Bylaws (Organization and Functions Manual). A special meeting of any committee may be called at the request of the committee chair or by the Chief of Staff.
- 7.2.2 A quorum is those Medical Staff members present and eligible to vote on an issue(s).

7.3 Attendance Requirements

- 7.3.1 Members of the Medical Staff are encouraged to attend meetings of committees they are appointed to and Medical Staff meetings. Meeting attendance will not be used in evaluating members at the time of reappointment.
- 7.3.2 MEC and Credentials Committee members are expected to attend at least seventy-five percent (75%) of the meetings held.

7.4 Special Meeting Attendance Requirements

Whenever there is a reason to believe that a practitioner is not complying with Medical Staff or Hospital policies/procedures or has deviated from standard clinical or professional practice, the CEO/President, Chief of Staff or the applicable department or committee chair may require the practitioner to confer with him or her, or with the MEC, or ad hoc committee that is considering the matter. The practitioner will be given special notice of the meeting at least five (5) days prior to the meeting. This notice shall include the date, time, place, a statement of the issue involved and that the practitioner's appearance is mandatory. Failure of the practitioner to appear at any such meeting after two (2) notices, unless excused by the MEC or ad hoc committee upon showing good cause, will result in an automatic termination of the practitioner's membership and privileges. Such termination would not give rise to a fair hearing, but will automatically be rescinded upon the practitioner's participation in the previously referenced meeting.

7.5 Participation by the Hospital CEO/President

The Hospital CEO/President (or designee) may attend any general, committee, or department meetings of the Medical Staff as an ex-officio member to encourage participation of management to assist the Medical Staff. The committee may go into executive session, with Medical Staff members only, when desired.

7.6 Robert's Rules of Order

Medical Staff and committee meetings shall be run in a manner determined by the chair of the meeting. When parliamentary procedure is needed, as determined by the chair or evidenced by a majority vote of those attending the meeting, the latest edition of *Robert's Rules of Order* shall determine procedure.

7.7 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.

7.8 Action of Committee or Department/Clinical Service

The recommendation of a majority of its voting members present at a meeting shall be the action of a committee, department or clinical service. Such recommendation will then be forwarded to the MEC for review and appropriate action.

7.9 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 or be counted in determining the existence of a quorum.

7.10 Minutes

Minutes of each regular and special meeting of a committee, department, clinical service, or Medical Staff shall be prepared and shall include a record of the attendance of members and the vote taken on each

matter. The presiding Chair shall authenticate the minutes and copies thereof shall be submitted to the MEC, or other designated committee. A permanent file of the minutes of each meeting shall be maintained.

Section 8. Medical Staff Conflict of Interest

8.1 Conflict of Interest

- 8.1.1 Members of the Medical Staff shall disclose any conflict of interest, as described by the Board, or potential conflict of interest in any transaction, occurrence or circumstance which exists or may arise with respect to his or her participation on any committee or in his or her activities in Medical Staff affairs, including in departmental activities and in the review of cases. Where such a conflict of interest exists or may arise, the Medical Staff member shall not participate in the activity, or as appropriate, shall abstain from voting. This provision does not prohibit any person from voting for himself or herself.
- 8.1.2 When performing a function outlined in the Bylaws, applicable policies/procedures, or the Rules and Regulations, if any Medical Staff member has or reasonably could be perceived as having a conflict of interest or a bias in any credentialing or peer review matter involving another individual, the individual with a conflict shall not participate in the final discussion or voting on the matter and shall be excused from any meeting during that time. However, the individual may provide relevant information and may answer any questions concerning the matter before leaving.
- 8.1.3 Any Medical Staff member with knowledge of the existence of a potential conflict of interest or bias on the part of any other member may call the conflict of interest to the attention of Chief of Staff (or to the Vice Chief if the Chief of Staff is the person with the potential conflict), or the Committee Chair. The Chief of Staff or the Committee Chair will make a final determination as to whether the provisions in Section 8.1 should be triggered.
- 8.1.4 The fact that a Medical Staff member is in the same specialty as a member whose performance is being reviewed does not automatically create a conflict. In addition, the evaluation of whether a conflict of interest exists shall be interpreted reasonably by the persons involved, taking into consideration common sense and objective principles of fairness. No Medical Staff member has a right to compel disqualification of another Medical Staff member based on an allegation of conflict of interest.
- 8.1.5 The fact that a committee member or Medical Staff leader chooses to refrain from participation, or is excused from participation, shall not be interpreted as a finding of actual conflict.

8.2 Indemnification

- 8.2.1 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.
- 8.2.2 Subject to applicable law, the Hospital shall indemnify against actual 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 or she is made a party by reason of his or her 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 constitute willful misconduct, breach of fiduciary duty, or bad faith.

Section 9. Conflict Management/Resolution

9.1 Conflicts between the Board and the MEC

The Medical Staff, in partnership with the Board, will make best efforts to address and resolve all conflicting recommendations in the best interests of patients, the Hospital, and the members of the Medical Staff. When the Board plans to act or is considering acting in a manner contrary to a recommendation made by the MEC, the Medical Staff officers shall meet with the Board, or a designated committee of the Board and Administration, and seek to resolve the conflict through informal discussions. If these informal discussions fail to resolve the conflict, the Chief of Staff or the Chair of the Board may request initiation of a formal conflict resolution process. This formal conflict resolution process will begin with a meeting of the Joint Conference Committee within thirty (30) days of the initiation of the formal conflict resolution process.

9.1.1 To address Board-MEC conflicts, the Joint Conference Committee shall be composed of:

- a. Officers of the Medical Staff;
- b. One (1) other MEC member or Medical Staff member at large chosen by the MEC;
- c. Chair, Vice Chair and Secretary of the Board or other designees of the Board; and
- d. CEO/President of the Hospital (or designee).

9.1.2 If the Joint Conference Committee cannot produce a resolution to the conflict that is acceptable to the MEC and the Board within thirty (30) days of the initial meeting, the MEC and the Board shall enter into mediation facilitated by an outside party. The MEC and Board shall together select the third-party mediator. The MEC and the Board shall make best efforts to collaborate together and with the third-party mediator to resolve the conflict. The Board and the MEC shall each designate at least three (3) individuals to participate in the mediation. Any resolution arrived at during such meeting shall be subject to the approval of the MEC and the Board, in accordance with the provisions of Medical Staff Bylaws and the Bylaws of the Hospital. If, after ninety (90) days from the date of the initial request for mediation from an outside party, the MEC and Board cannot resolve the conflict in a manner agreeable to all parties, the Board shall have the authority to act unilaterally on the issue that gave rise to the conflict.

9.1.3 If the Board determines, in its sole discretion, that action must be taken related to a conflict in a shorter time period in an attempt to address an issue of quality, patient safety, liability, regulatory compliance, legal compliance, or other critical obligations of the Hospital, the Board may take provisional action that will remain in effect until the conflict resolution process is completed.

9.1.4 In addition to the formal conflict resolution process herein described, the Chair of the Board or the Chief of Staff may call for a meeting of the Joint Conference Committee at any time and for any reason to seek direct input from the Joint Conference Committee members, clarify any issue, or relay information directly to Medical Staff leaders, the Board or Administration.

9.2 Conflicts between the Medical Staff and the MEC

The MEC, as representatives of the Medical Staff, will make best efforts to address and resolve all conflicting recommendations in the best interests of patients, the Hospital, and the members of the

Medical Staff. When the MEC plans to act or is considering acting in a manner contrary to the wishes of the voting members of the Medical Staff, the Medical Staff shall present their recommendation to the MEC with a written petition signed by at least fifty percent (50%) of the voting members of the Medical Staff. The Medical Staff officers shall meet with members of the Medical Staff representing the Medical Staff's recommendations as set forth in the petition and seek to resolve the conflict through informal discussions. If these informal discussions fail to resolve the conflict, the Chief of Staff, the representatives of the Medical Staff or the Chair of the Board may request initiation of a formal conflict resolution process. The formal conflict resolution process will begin with a meeting of the Joint Conference Committee within thirty (30) days of the initiation of the formal conflict resolution process.

9.2.1 To address Medical Staff-MEC conflicts, the Joint Conference Committee shall be composed of:

- a. Officers of the Medical Staff;
- b. One (1) other MEC member or Medical Staff member at large chosen by the MEC;
- c. Chair, Vice Chair and Secretary of the Board or other designees of the Board; and
- d. CEO/President of the Hospital (or designee).

9.2.2 If the Joint Conference Committee cannot produce a resolution to the conflict that is acceptable to the MEC and the Medical Staff within thirty (30) days of the initial meeting, the MEC and the Medical Staff shall enter into mediation facilitated by an outside party. The MEC and three (3) voting members of the Medical Staff representing the recommendations in the written petition shall together select the third-party mediator, the costs for which shall be paid in total by the Medical Staff. The MEC and the Medical Staff shall make best efforts to collaborate together and with the third-party mediator to resolve the conflict. The MEC and the Medical Staff shall each designate at least three (3) individuals to participate in the mediation. Any resolution arrived at during such meeting shall be subject to the approval of the MEC and the Board, in accordance with the provisions of Medical Staff Bylaws and the Bylaws of the Hospital. If, after ninety (90) days from the date of the initial request for mediation from an outside party, the MEC and Medical Staff cannot resolve the conflict in a manner agreeable to all parties, the Board shall have the authority to act unilaterally on the issue that gave rise to the conflict.

9.2.3 If the Board determines, in its sole discretion, that action must be taken related to a conflict in a shorter time period than that allowed through this conflict resolution process in an attempt to address an issue of quality, patient safety, liability, regulatory compliance, legal compliance, or other critical obligations of the Hospital, the Board may take provisional action that will remain in effect until the conflict resolution process is completed.

9.2.4 In addition to the formal conflict resolution process herein described, the Chair of the Board or the Chief of Staff may call for a meeting of the Joint Conference Committee at any time and for any reason to seek direct input from the Joint Conference Committee members, clarify any issue, or relay information directly to Medical Staff leaders, the Board or Administration.

Section 10. Review, Revision, Adoption, and Amendment

10.1 Medical Staff Responsibility

The Board shall require the Medical Staff to adopt and enforce Bylaws to carry out its Medical Staff functions. The Board shall require that the Medical Staff Bylaws, Rules and Regulations, and policies/procedures comply with local, State and Federal law and regulations, and the requirements of the

Medicare Hospital Conditions of Participation, and applicable accreditation standards. The Medical Staff Bylaws shall be adopted upon the approval of the Medical Staff and become effective upon the approval by the Board. The Medical Staff Rules and Regulations shall be adopted upon the approval of the Medical Executive Committee, acting on behalf of the Medical Staff, and become effective upon approval by the Board. Medical Staff Rules and Regulations and Policies/Procedures may contain the associated detail for provisions in the Medical Staff Bylaws. "Associated details" are the procedural steps necessary to describe, implement, enforce, or otherwise operationalize the provisions of the Bylaws. Such responsibility shall be exercised in good faith and in a reasonable, responsible and timely manner.

The Medical Staff shall comply with and enforce the Medical Staff Bylaws, Rules and Regulations and Medical Staff policies/procedures.

10.2 Methods of Adoption and Amendment to these Bylaws

10.2.1 Proposed amendments to these Bylaws may be originated by the MEC or by a petition signed by fifty percent (50%) of the voting members of the Medical Staff. When proposed by the MEC, there will be communication of the proposed amendment to the Medical Staff before a vote is taken by the MEC. All voting members of the Medical Staff shall receive at least thirty (30) days advance notice of the proposed change.

If the proposed revision is made by written petition of voting members of the Medical Staff, the Medical Staff members shall communicate the proposed amendment via written notice of the proposed change to all members of the MEC no less than thirty (30) days prior to the meeting upon which the Bylaws changes are to be voted on by the Medical Staff.

The notices shall include the exact wording of the existing Bylaws language, if any, and the proposed change(s). Each voting 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. To be adopted, the Medical Staff receives a simple majority of the votes cast by those members eligible to vote.

If the Medical Staff approves the proposed amendment(s), the MEC will forward the proposed amendment to the Board noting approval by both the MEC and the Medical Staff.

In the event of a conflict within the Medical Staff regarding the Medical Staff Bylaws, the Medical Staff process for conflict management/resolution shall be implemented as set forth in Section 9.

Bylaws changes adopted by the Medical Staff shall become effective following approval by the Board, which approval shall not be unreasonably withheld. Following significant changes to the Bylaws, Rules and Regulations or Medical Staff Policies/Procedures, Medical Staff members shall be provided with a revised text.

10.2.2 Neither the Board nor the Medical Staff may unilaterally amend the Medical Staff Bylaws or Rules or Regulations, except as set forth herein. As required by the Medicare Conditions of Participation and other regulatory requirements, the Board shall maintain complete and ultimate responsibility and authority over the Hospital and Medical Staff. In the event of a documented need for an urgent amendment of the Medical Staff Bylaws in which the Medical Staff and the MEC are incapable of, or refuse to amend the Medical Staff Bylaws to comply with local, State or Federal laws and regulations, or to address a documented concern that could adversely affect patient safety or quality of care, the Board shall exercise its authority in such a situation to unilaterally

amend the Medical Staff Bylaws or Rules and Regulations as necessary to address an issue of quality, patient safety, liability, regulatory compliance, legal compliance, or other critical obligations of the Hospital after first exhausting reasonable efforts to gain the MEC's or Medical Staff's approval, including the conflict management/resolution process as set forth in Section 9. In such a situation, the Board's amendment shall be final, and all voting members of the Medical Staff shall be notified of the amendment within ten (10) days of the amendment becoming final.

10.3 Methods of Adoption and Amendment to Medical Staff Rules and Regulations and/or Policies/Procedures

10.3.1 Proposed amendments to the Rules and Regulations or policy may be originated by the MEC or a petition signed by fifty percent (50%) of the voting members of the Medical Staff. When proposed by the MEC, there will be communication of the proposed amendment to the Medical Staff before a vote is taken by the MEC. When proposed by the Medical Staff, there will be communication of the proposed amendment to the MEC.

In the event of a conflict within the Medical Staff regarding the Medical Staff Rules and Regulations and/or policies/procedures, the Medical Staff process for conflict management/resolution shall be implemented as set forth in Section 9.

10.3.2 The MEC shall vote on the proposed language changes at a regular meeting, or at a special meeting called for such purpose. If the MEC approves of the proposed Rule or Regulation, the MEC will forward the proposed Rule or Regulation to the Board noting approval by both the Medical Staff and the MEC. If the MEC does not approve of the proposed Rule or Regulation, the MEC will forward the proposed Rule or Regulation to the Board noting the approval by the Medical Staff and the disapproval by the MEC. Such changes shall be effective when approved by the Board.

10.3.3 Medical Staff policies/procedures will become effective upon approval of the MEC and will be forwarded to the Board as information only. If the Medical Staff disagrees with a policy or procedure enacted by the MEC, it can utilize the conflict management/resolution mechanism in Section 9. When the MEC adopts a Medical Staff policy or amendment thereto, there will be communication of the policy or amendment to the Medical Staff.

10.3.4 In the event of a documented need for an urgent amendment of the Medical Staff Bylaws to comply with law or regulation or accreditation standards, the MEC may provisionally adopt and the Board may provisionally approve the urgent amendment without prior notification of the voting members of the Medical Staff. In such cases, the voting members of the Medical Staff shall be immediately notified by the MEC of the urgent amendment within ten (10) days after the Board has approved the amendment. The members of the Medical Staff shall have an additional twenty (20) days within which to retrospectively review the amendment and provide written comment to the MEC. If there are no comments opposing the provisional amendment, then the provisional amendment shall become final. If there are comments opposing the provisional amendment, then the Medical Staff process for conflict management/resolution as noted in Section 9 shall be implemented and a revised amendment shall be submitted to the Board if necessary. If a substitute amendment is then proposed, it will follow the usual approval process.

10.3.5 The MEC may adopt such amendments to these Bylaws, Rules and Regulations and policies/procedures that are, in the MEC's judgment, technical or legal modifications or clarifications. 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/President.

Section 11. Adoption and Approval

The Medical Staff Bylaws of Mercy Hospital Joplin have been approved and adopted as listed below:

02/06/2015 Board



MERCY HOSPITAL JOPLIN

MEDICAL STAFF BYLAWS

**PART II: INVESTIGATIONS, CORRECTIVE ACTIONS,
HEARING AND APPEAL PLAN**

June 25, 2012

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1.1 Criteria for Initiation

These Bylaws encourage Medical Staff leaders and Hospital management to use progressive steps, beginning with collegial and education efforts, to address questions relating to a practitioner's clinical practice and/or professional conduct. The goal of these progressive steps is to help the practitioner voluntarily respond to and resolve questions that have been raised. All collegial intervention efforts by Medical Staff leaders and Hospital management shall be considered confidential and part of the Hospital's performance improvement and professional and peer review activities. Collegial intervention efforts are encouraged, but are not mandatory, and shall be within the discretion of the appropriate Medical Staff leaders and Hospital management. When any observations arise suggesting opportunities for a practitioner to improve, the matter should be referred for peer review in accordance with the peer review and performance improvement policies/procedures adopted by the medical staff and hospital. Collegial intervention efforts may include but are not limited to the following:

- a. Educating and advising colleagues of all applicable policies/procedures, including those related to appropriate behavior, emergency call obligations, and the timely and adequate completion of medical records;
- b. Following up on any questions or concerns raised about the clinical practice and/or conduct of privileged practitioners and recommending such steps as proctoring, monitoring, consultation, and letters of guidance; and
- c. Sharing summary comparative quality, utilization and other relevant information to assist practitioners to improve efficiencies to conform their practices to appropriate standards.

Following collegial intervention efforts, if it appears that the practitioner's performance places patients in danger or compromises the quality of care, or in cases where it appears that patients may potentially be harmed while collegial interventions are undertaken, the Medical Executive Committee (MEC) will consider whether it should be recommended to the Board to restrict or revoke the practitioner's membership and/or privileges. Before issuing such a recommendation, the MEC will authorize an investigation to determine whether sufficient evidence exists to support such a recommendation.

Any person may provide information to any member of the MEC about the conduct, performance, or competence of a Medical Staff member(s). When reliable information indicates a member may have exhibited acts, demeanor, or conduct, reasonably likely to be (1) detrimental to patient safety or to the delivery of quality patient care; (2) unethical; (3) contrary to the Hospital's Medical Staff Bylaws, Rules and Regulations, or policies/procedures; or (4) below applicable professional standards, a request for an investigation or action against such member may be initiated by the Chief of Staff, CEO/President, or the MEC.

Section 2. Investigations

2.1 Initiation

A request for an investigation must be submitted by a committee chair, clinical service chair, department chair, or CEO/President to the MEC. The request must be supported by references to the specific activities or conduct that is of concern. If the MEC initiates the request, it shall appropriately document its reasons.

2.2 Investigation

If the MEC decides that an investigation is warranted, it shall direct an investigation to be undertaken through a formal resolution. In the event the Board believes the MEC has incorrectly determined that an investigation is unnecessary, it may direct the MEC to proceed with an investigation.

The MEC may conduct the investigation itself or may assign the task to an appropriate standing or ad hoc committee of the Medical Staff.

If the investigation is delegated to an officer or committee other than the MEC, such committee shall proceed with the investigation promptly and forward a written report of its findings, conclusions, and recommendations, to the MEC as soon as feasible. The committee conducting the investigation shall have the authority to review all documents it considers relevant, to interview individuals, to consider appropriate clinical literature and practice guidelines, and to utilize the resources of an external consultant if it deems a consultant is necessary and such action is approved by the MEC and the CEO/President. The investigating body may also require the practitioner under review to undergo a physical and/or mental examination and may access the results of such exams. The investigating body shall notify the practitioner in question that the investigation is being conducted and an opportunity to provide information in a manner and upon such terms as the investigating body deems appropriate. The meeting between the practitioner in question and the investigating body (and meetings with any other individuals the investigating body chooses to interview) shall not constitute a "hearing" as that term is used in the hearing and appeals section (Part II, Section 4 through 7) of these Bylaws. The procedural rules with respect to hearings or appeals shall not apply to these meetings either. The practitioner being investigated shall not have the right to be represented by legal counsel before the investigating body nor to compel the investigating body to engage external consultation. Despite the status of any investigation, the MEC shall retain the authority and discretion to take whatever action may be warranted by the circumstances, including suspension, termination of the investigative process; or other action.

2.2.1 An external peer review consultant should be considered when:

- a. Litigation seems likely; an outside source review may be the best course of action in these circumstances. Every step should be taken to avoid even the appearances that the external reviewers are being asked to achieve a certain result.
- b. The Hospital is faced with ambiguous or conflicting recommendations from the Medical Staff committees, or where there does not appear to be a strong consensus for a particular recommendation. In these circumstances consideration may be given by the MEC, or the Board to retain an objective external reviewer;
- c. There is no one on the Medical Staff with expertise in the subject under review, or when the only physician on the Medical Staff with appropriate expertise are direct competitors, partners, or associates of the physician under review.

2.3 MEC Action

As soon as feasible after the conclusion of the investigation, the MEC shall take action that may include, without limitation:

- a. Determining no corrective action is warranted;
- b. Deferring action for a reasonable time when circumstances warrant;
- c. Issuing letters of admonition, censure, reprimand, or warning, although nothing herein shall be deemed to preclude the Chief of Staff from issuing informal written or oral warnings prior to an investigation. In the event such letters are issued, the affected practitioner may make a written response, which shall be placed in the practitioner's file;
- d. Recommending the imposition of terms of probation or special limitation upon continued Medical Staff membership or exercise of clinical privileges, including, without limitation, requirements for co-admissions, mandatory consultation, or monitoring/proctoring;
- e. Recommending denial, restriction, modification, reduction, suspension, revocation, or probation of clinical privileges;
- f. Recommending reductions of membership status or limitation of any prerogatives directly related to the member's delivery of patient care;
- g. Recommending suspension, revocation, or probation of Medical Staff membership; or
- h. Taking other actions deemed appropriate under the circumstances.

2.4 Subsequent Action

If the MEC recommends any termination or restriction of the practitioners membership or privileges, that recommendation shall be transmitted in writing to the Board. The recommendation of the MEC shall be forwarded to the Board unless the practitioner requests a hearing, in which case the final decision shall be determined as set forth in this Hearing and Appeal plan (Part II, Section 4 through 7).

Section 3. Corrective Action

3.1 Automatic Relinquishment/Voluntary Resignation

In the following instances, the practitioner's clinical privileges and/or membership will be considered relinquished, or limited as described, and the action shall be final without a right to hearing. Where a bona fide dispute exists as to whether the circumstances have occurred, the relinquishment, suspension, or limitation will stand until the MEC determines it is not applicable. The MEC will make such a determination as soon as feasible. The Chief of Staff with the approval of the CEO/President may reinstate the practitioner's privileges and/or membership after determining that the triggering circumstances have rectified or are no longer present. If the triggering circumstances have not been resolved within sixty (60) days, the practitioner will have to reapply for membership and/or privileges and pay applicable fees. In addition, further corrective action may be recommended in accordance with these Bylaws whenever any of the following actions occur:

3.1.1 Licensure

- a. Revocation and Suspension: Whenever a practitioner's license or other legal credential

- authorizing practice in this state is revoked, suspended, expired, or voluntarily relinquished, Medical Staff membership and clinical privileges shall be automatically relinquished by the practitioner as of the date such action becomes effective.
- b. Restriction: Whenever a practitioner's license or other legal credential authorizing practice in this state is limited or restricted by an applicable licensing or certifying authority, any clinical privileges that the practitioner has been granted which are within the scope of said limitation or restriction shall be automatically limited or restricted in a similar manner, as of the date such action becomes effective and throughout its term.
 - c. Probation: Whenever a practitioner is placed on probation by the applicable licensing or certifying authority, his or her membership status and clinical privileges shall automatically become subject to the same terms and conditions of the probation as of the date such action becomes effective and throughout its term.
 - d. Medicare, Medicaid, Tricare and/or other Federal and State Healthcare Programs: It being essential that Medical Staff provide care for patients in Medicare, Medicaid, Tricare and/or other Federal and State Healthcare Programs, whenever a practitioner is sanctioned or barred from any of these programs, Medical Staff membership and/or clinical privileges shall be considered automatically relinquished as of the date such action becomes effective. Any practitioner listed on the United States Department of Health and Human Services of the Inspector General's List of Excluded Individuals/Entities (including those practitioners who are on the State Opt-Out List and thereby have opted-out of Medicare) will be considered to have automatically relinquished his or her membership and clinical privileges.

3.1.2 Controlled Substances

- a. DEA certificate: Whenever a practitioner's United States Drug Enforcement Agency (DEA) certificate is revoked, limited, or suspended, the practitioner will automatically and correspondingly be divested of the right to prescribe medications covered by the certificate, as of the date such action becomes effective and throughout its term.
- b. Probation: Whenever a practitioner's DEA certificate is subject to probation, the practitioner's rights to prescribe such medications shall automatically become subject to the same terms of the probation, as of the date such action becomes effective and throughout its term.

3.1.3 Medical Record Completion Requirements: A practitioner will be considered to have voluntarily relinquished the privilege to admit new patients or schedule new procedures whenever he or she fails to complete medical records within time frames established by the MEC. This relinquishment of privileges shall not apply to patients admitted or already scheduled at the time of relinquishment, to emergency patients, or to imminent deliveries. The relinquished privileges will be automatically restored upon completion of the medical records and compliance with medical records policies/procedures.

3.1.4 Professional Liability Insurance: Failure of a practitioner to maintain professional liability insurance in the amount established by the Board and sufficient to cover the clinical privileges granted shall result in immediate automatic relinquishment of practitioner's clinical privileges. If within sixty (60) calendar days of the relinquishment the practitioner does not provide evidence of required professional liability insurance (including tail coverage for any period during which insurance was not maintained), the practitioner shall not be considered for reinstatement and shall be considered to have voluntarily resigned from the Medical Staff. The practitioner must

notify Medical Staff Services immediately of any change in professional liability insurance carrier or coverage.

- 3.1.5 Medical Staff Dues/Special Assessments: Failure to promptly pay Medical Staff dues or any special assessment shall be considered an automatic relinquishment of a practitioner's appointment. If within ninety (90) calendar days after written warning of the delinquency the practitioner does not remit such payments, the practitioner shall be considered to have voluntarily resigned membership on the Medical Staff.
- 3.1.6 Felony/Misdemeanor Conviction: A practitioner who has been convicted of or pled "guilty" or "no contest" or its equivalent to a felony or to a misdemeanor involving a charge of immoral action in any jurisdiction shall automatically relinquish Medical Staff membership and privileges. Such relinquishment shall become effective immediately upon such conviction or plea regardless of whether an appeal is filed. Such relinquishment shall remain in effect until the matter is resolved by subsequent action of the Board or through corrective action, if necessary.
- 3.1.7 Failure to Satisfy the Special Appearance Requirement: A practitioner who fails without good cause to appear at a meeting where his or her special appearance is required in accordance with these Bylaws shall be considered to have automatically relinquished all clinical privileges with the exception of emergencies and imminent deliveries. These privileges will be restored when the practitioner complies with the special appearance requirement. Failure to comply within thirty (30) calendar days will be considered a voluntary resignation from the Medical Staff.
- 3.1.8 Failure to Participate in an Evaluation: A practitioner who fails to participate in an evaluation of his or her qualifications for Medical Staff membership or privileges as required under these Bylaws (whether an evaluation of physical or mental health or of clinical management skills) shall be considered to have automatically relinquished all privileges. These privileges will be restored when the practitioner complies with the requirement for an evaluation. Failure to comply within thirty (30) calendar days will be considered a voluntary resignation from the Medical Staff.
- 3.1.9 Failure to become Board Certified or failure to maintain Board Certification: A practitioner who fails to become board certified or maintain board certification in compliance with these Bylaws or Medical Staff credentialing policies/procedures will be deemed to have immediately and voluntarily relinquished his or her Medical Staff appointment and clinical privileges unless an exception is granted by the Board upon recommendation from the MEC.
- 3.1.10 Failure to Execute Release and/or Provide Documents: A practitioner who fails to execute a general or specific release and/or provide documents when requested by the Chief of Staff (or designee) to evaluate the competency and credentialing/privileging qualifications of the practitioner shall be considered to have automatically relinquished all privileges. If the release is executed and/or documents provided within thirty (30) calendar days of notice of the automatic relinquishment, the practitioner may be reinstated. Thereafter, the practitioner will be deemed to have resigned voluntarily from the Medical Staff and must reapply for staff membership and privileges.
- 3.1.11 Leave of Absence: Failure, without good cause, to request reinstatement, to submit complete information or to provide a requested summary of activities as provided before termination of the leave may result in automatic relinquishment of Medical Staff membership, privileges and prerogatives, and/or employment without the right of a fair hearing.

3.1.12 MEC Deliberation: As soon as practicable after action is taken or warranted as described in Sections 3.1.1 through Section 3.1.11, the MEC shall convene to review and consider the facts, and may recommend such further corrective action as it may deem appropriate following the procedure generally set forth in the Section 2.3 above.

3.2 Summary Restriction or Suspension

3.2.1 Criteria for Initiation: A summary restriction or suspension may be imposed when the Medical Staff feels that it needs immediate action to be taken to protect the life or well-being of patient(s); or to reduce a substantial and imminent likelihood of significant impairment of the life, health, and safety of any person or when Medical Staff leaders and/or the CEO/President determines that there is a need to carefully consider any event, concern, or issue, that, if confirmed, has the potential to affect patient or co-worker or the effective operation of the institution. Under such circumstances either the CEO/President (or designee), Chief of Staff (or designee), or the MEC may restrict or suspend the Medical Staff membership or clinical privileges of such practitioner as a precaution. A suspension of all or any portion of a practitioner's clinical privileges at another hospital may be grounds for a summary suspension of all or any of the practitioner's clinical privileges at this hospital.

Unless otherwise stated, such summary restriction or suspension shall become effective immediately upon imposition and the person or body responsible shall promptly give written notice to the practitioner, the MEC, the CEO/President, and the Board. The restriction or suspension may be limited in duration and shall remain in effect for the period stated or, if none, until resolved as set forth herein. The summary suspension is not a complete professional review action in and of itself, and it shall not imply any final finding regarding the circumstances that caused the suspension

Unless otherwise indicated by the terms of the summary restriction or suspension, the practitioner's patients shall be promptly assigned to another Medical Staff member by the Chief of Staff (or designee) considering, where feasible, the wishes of the affected practitioner and the patient in the choice of a substitute practitioner.

3.2.2 MEC Action: As soon as feasible and within fourteen (14) calendar days after such summary suspension has been imposed, the MEC shall meet to review and consider the action and if necessary begin the investigation process as noted in Section 2.2 above. Upon request and at the discretion of the MEC, the practitioner will be given the opportunity to address the MEC concerning the action, on such terms and conditions as the MEC may impose, although in no event shall any meeting of the MEC, with or without the practitioner, constitute a "hearing" as defined in this hearing and appeal plan (Part II, Section 4 through 7), nor shall any procedural rules with respect to hearing and appeal apply. The MEC may modify, continue, or terminate the summary restriction or suspension, but in any event it shall furnish the practitioner with notice of its decision.

3.2.3 Procedural Rights: Unless the MEC promptly terminates the summary restriction or suspension prior to or immediately after reviewing the results of any investigation described in Section 2, the members shall be entitled to the procedural rights afforded by this hearing and appeal plan (Part II, Section 4 through 7) once the restrictions or suspension last more than fourteen (14) calendar days.

Section 4. Initiation and Notice of Hearing

4.1 Initiation of Hearing

Any practitioner eligible for Medical Staff appointment or physician eligible for privileges without membership shall be entitled to request a hearing whenever an unfavorable recommendation with regard to clinical competence or professional conduct has been made by the MEC or the Board. Hearings will be triggered only by the following actions when the basis for such action is related to clinical competence or professional conduct:

- a. Denial of Medical Staff appointment or reappointment;
- b. Revocation of Medical Staff appointment;
- c. Denial or restriction of requested clinical privileges;
- d. Reduction in clinical privileges;
- e. Involuntary reduction or revocation of clinical privileges;
- f. Application of a mandatory concurring consultation requirement, or an increase in the stringency of a pre-existing mandatory concurring consultation requirement, when such requirement only applies to an individual Medical Staff member and is imposed for more than thirty (30) calendar days or;
- g. Suspension of Medical Staff appointment or clinical privileges, but only if such suspension is for more than thirty (30) days and is not caused by the member's failure to complete medical records or any other reason unrelated to clinical competence or professional conduct.

4.2 Hearings Will Not Be Triggered by the Following Actions

- a. Issuance of a letter of guidance, warning or reprimand;
- b. Imposition of a requirement for proctoring (i.e. observation of the practitioner's performance by a peer in order to provide information to a Medical Staff peer review committee) with no restriction on privileges;
- c. Failure to process a request for a privilege when the applicant/member does not meet the eligibility criteria to hold that privilege;
- d. Conducting an investigation into any matter or the appointment of an ad hoc investigation committee;
- e. Requirement to appear for a special meeting under the provisions of these Bylaws;
- f. Automatic relinquishment or voluntary resignation of appointment or privileges;
- g. Imposition of a summary suspension or administrative suspension that does not exceed thirty (30) calendar days;
- h. Denial of a request for a leave of absence, or for an extension of a leave;
- i. Determination that an application is incomplete or untimely;
- j. Determination that an application will not be processed due to misstatement or omission;
- k. Decision not to expedite an application;
- l. Termination or limitation of temporary privileges unless for demonstrated incompetence or unprofessional conduct;
- m. Determination that an applicant for membership does not meet the required qualifications/criteria for membership;
- n. Ineligibility to request membership or privileges or continue privileges because a relevant specialty is closed under a medical staff development plan or covered under an exclusive provider agreement;

- o. Imposition of supervision pending completion of an investigation to determine whether corrective action is warranted;
- p. Termination of any contract with or employment by Hospital;
- q. Proctoring, monitoring, and any other performance monitoring requirements imposed in order to fulfill any accreditation standards on focused professional practice evaluation;
- r. Any recommendation voluntarily accepted by the practitioner;
- s. Expiration of membership and privileges as a result of failure to submit an application for reappointment within the allowable time period;
- t. Change in assigned staff category;
- u. Refusal of the MEC to consider a request for appointment, reappointment, or privileges within five (5) years of a final adverse decision regarding such request;
- v. Removal or limitations of emergency department call obligations;
- w. Any requirement to complete an education assessment;
- x. Retrospective chart review;
- y. Any requirement to complete a health and/or psychiatric/psychological assessment required under these Bylaws;
- z. Grant of conditional appointment or appointment for a limited duration; or
- aa. Appointment or reappointment for duration of less than twenty-four (24) months.

4.3 Notice of Recommendation

When a summary suspension lasts longer than thirty (30) calendar days or when a recommendation is made, which, according to this plan entitles a practitioner to request a hearing prior to a final decision of the Board, the affected practitioner shall promptly (but no longer than five (5) calendar days) be given written notice by the CEO/President either in person or by certified mail, return receipt requested. This notice shall contain:

- a. A statement of the recommendation made and the general reasons for it (Statement of Reasons);
- b. Notice that the practitioner shall have thirty (30) calendar days following the date of receipt of such notice within which to request a hearing on the recommendation;
- c. Notice that the recommendation, if finally adopted by the Board, may result in a report to the state licensing authority (or other applicable state agencies) and the National Practitioner Data Bank; and
- d. The practitioner shall receive a copy of Part II (Investigations, Corrective Action, Hearing and Appeal Plan) of these Bylaws outlining procedural rights with regard to the hearing.

4.4 Request for Hearing

Such practitioner shall have thirty (30) days following the date of the receipt of such notice to request the hearing. The request shall be made in writing to the CEO/President (or designee). In the event the affected practitioner does not request a hearing within the time and in the manner required by Part II (Investigations, Corrective Action, Hearing and Appeal Plan) of these Bylaws, the practitioner shall be deemed to have waived the right to such hearing and to have accepted the recommendation made. Such recommended action shall become effective immediately upon final Board action.

4.5 Notice of Hearing and Statement of Reasons

The CEO/President shall schedule the hearing and shall give written notice, certified mail return receipt requested, to the practitioner who requested the hearing. The notice shall include:

- a. The time, place and date of the hearing;
- b. A proposed list of witnesses (as known at that time, but which may be modified) who will give testimony of evidence in support of the MEC, (or the Board) at the hearing;
- c. The names of the hearing panel members and presiding officer or hearing officer, if known; and
- d. A statement of the specific reasons for the recommendation as well as the list of patient records and/or information supporting the recommendation. This statement, and the list of supporting patient record numbers and other information, may be amended or added to at any time, even during the hearing so long as the additional material is relevant to the continued appointment or clinical privileges of the practitioner requesting the hearing, and that the practitioner and the practitioner's counsel have sufficient time to study this additional information.

The hearing shall begin as soon as feasible, but no sooner than thirty (30) calendar days after the notice of the hearing unless an earlier hearing date has been specifically agreed to in writing by both parties.

4.6 Witness List

At least fifteen (15) calendar days before the hearing, each party shall furnish to the other a written list of the names of the witnesses intended to be called. Either party may request that the other party provide either a list of, or copies of, all documents that will be offered as pertinent information or relied upon by witnesses at the Hearing Panel and which are pertinent to the basis for which the disciplinary action was proposed. The witness list of either party may, in the discretion of the presiding officer, be supplemented or amended at any time during the course of the hearing, provided that notice of the change is given to the other party. The presiding officer shall have the authority to limit the number of witnesses.

Section 5: Hearing Panel and Presiding Officer or Hearing Officer

5.1 Hearing Panel

- 5.1.1 When a hearing is requested, a hearing panel of not fewer than three (3) individuals will be appointed. This panel will be appointed by the CEO/President after considering the recommendations of the MEC Chair. No individual appointed to the hearing panel shall have actively participated in the consideration of the matter involved at any previous level. However, mere knowledge of the matter involved shall not preclude any individual from serving as a member of the hearing panel. Employment by, or a contract with, the Hospital or an affiliate shall not preclude any individual from serving on the hearing panel. Hearing panel members need not be a member of the Medical Staff. When the issue before the panel is a question of clinical competence, all panel members shall be clinical practitioners. Panel members need not be clinicians in the same specialty as the practitioner requesting a hearing but it is highly encouraged.
- 5.1.2 The hearing panel shall not include any individual who is in direct economic competition with the affected practitioner or any such individual who is professionally associated with or related to the affected practitioner. This restriction on appointment shall include any individual designated as the chair or presiding officer.
- 5.1.3 The CEO/President (or designee) shall notify the practitioner requesting the hearing of the names of the panel members and the date by which the practitioner must object, if at all, to

appointment of any member(s). Any objection to any member of the hearing panel or to the hearing officer or presiding officer shall be made in writing to the CEO/President, who shall determine whether a replacement panel member should be identified. Although the practitioner who is the subject of the hearing may object to a panel member, he or she is not entitled to veto that member's participation. Final authority to appoint panel members will rest with the CEO/President.

5.2 Hearing Panel Chairperson or Presiding Officer

- 5.2.1 In lieu of a hearing panel chair, the CEO/President, acting for the Board and after considering the recommendations of the CEO/President and Chief of Staff may appoint an attorney at law or other individual experienced in legal proceedings as a presiding officer. The presiding officer should have no previous history with either the Hospital or the practitioner. Such presiding officer will not act as a prosecuting officer, or as an advocate for either side at the hearing. The presiding officer may participate in the private deliberations of the hearing panel and may serve as a legal advisor to it, but shall not be entitled to vote on its recommendation.
- 5.2.2 If no presiding officer has been appointed, a chair of the hearing panel shall be appointed by the CEO/President to serve as the presiding officer and shall be entitled to one (1) vote.
- 5.2.3 The presiding officer (or hearing panel chair) shall do the following:
- a. Act to insure that all participants in the hearing have a reasonable opportunity to be heard and to present oral and documentary evidence subject to reasonable limits on the number of witnesses and duration of direct and cross examination, applicable to both sides, as may be necessary to avoid cumulative or irrelevant testimony or to prevent abuse of the hearing process.
 - b. Prohibit conduct or presentation of evidence that is cumulative, excessive, irrelevant, or abusive, or that causes undue delay. In general, it is expected that a hearing will last no more than fifteen (15) hours;
 - c. Maintain decorum throughout the hearing;
 - d. Determine the order of procedure throughout the hearing;
 - e. Have the authority and discretion, in accordance with this policy, to make rulings on all questions that pertain to matters of procedure and to the admissibility of evidence;
 - f. Act in such a way that all information reasonably relevant to the continued appointment or clinical privileges of the practitioner requesting the hearing is considered by the hearing panel in formulating its recommendations;
 - g. Conduct argument by counsel on procedural points and may do so outside the presence of the hearing panel; and
 - h. Seek legal counsel when he or she feels it is appropriate. Legal counsel to the Hospital may advise the presiding officer or panel chair.

5.3 Hearing Officer

As an alternative to the hearing panel described in Section 5.1 above, the CEO/President, acting for the Board and after consultation and in conjunction with the Chief of Staff (or those of the Chair of the Board, if the hearing is occasioned by a Board determination) may instead appoint a hearing officer to perform the functions that would otherwise be carried out by the hearing panel. The hearing officer may be an attorney who has experience in health law.

The hearing officer may not be any individual who is in direct economic competition with the practitioner requesting the hearing, and shall not act as a prosecuting officer or as an advocate to either side at the hearing. In the event a hearing officer is appointed instead of a hearing panel, all references to the "hearing panel" or "presiding officer" shall be deemed to refer instead to the hearing officer, unless the context would clearly require otherwise.

Section 6. Pre-Hearing and Hearing Procedure

6.1 Provision of Relevant Information

- 6.1.1 There is no right to formal "discovery" in connection with the hearing. The presiding officer, hearing panel chair, or hearing officer shall rule on any dispute regarding discoverability and may impose any safeguards, including denial or limitation of discovery to protect the peer review process and ensure a reasonable and fair hearing. In general, the practitioner requesting the hearing shall be entitled, upon specific request, to the following, subject to stipulation signed by both parties, the practitioner's counsel and any experts that such documents shall be maintained as confidential consistent with all applicable state and federal peer review and privacy statutes and shall not be disclosed or used for any purpose outside of the hearing:
- a. Copies of, or reasonable access to, all patient medical records referred to in the Statement of Reason, at his or her expense;
 - b. Reports of experts relied upon by the MEC;
 - c. Copies of redacted relevant committee minutes;
 - d. Copies of other documents relied upon by the MEC, or the Board;
 - e. No information regarding other practitioners shall be requested, provided or considered; and
 - f. Evidence unrelated to the reasons for the recommendation or to the practitioner's qualifications for appointment or the relevant clinical privileges shall be excluded.
- 6.1.2 Prior to the hearing, on dates set by the presiding officer or agreed upon by counsel for both sides, each party shall provide the other party with all proposed exhibits. All objections to documents or witnesses to the extent then reasonably known shall be submitted in writing prior to the hearing. The presiding officer shall not entertain subsequent objections unless the party offering the objection demonstrates good cause.
- 6.1.3 Prior to the hearing, on dates set by the presiding officer, the practitioner requesting the hearing shall, upon specific request, provide the MEC, or the Board copies of any expert reports or other documents upon which the practitioner will rely at the hearing
- 6.1.4 There shall be no contact by the practitioner who is the subject of the hearing with those individuals appearing on the Hospital's witness list concerning the subject matter of the hearing; nor shall there be contact by the MEC or Hospital with individuals appearing on the affected practitioner's witness list concerning the subject matter of the hearing, unless specifically agreed upon by that practitioner or his or her counsel.

6.2 Pre-Hearing Conference

The presiding officer may require a representative for the practitioner and for the MEC, (or the Board) to participate in a pre-hearing conference. At the pre-hearing conference, the presiding officer shall resolve all procedural questions, including any objections to exhibits or witnesses, and determine the time allotted to each witness's testimony and cross-examination. The appropriate role of attorneys will be decided at the pre-hearing conference.

6.3 Failure to Appear

Failure, without good cause, of the practitioner requesting the hearing to appear and proceed at such a hearing shall be deemed to constitute a waiver of all hearing and appeal rights and a voluntary acceptance of the recommendations or actions pending, which shall then be forwarded to the Board for final action. Good cause for failure to appear will be determined by the presiding officer, chair of the hearing panel or hearing officer.

6.4 Record of Hearing

The hearing panel shall maintain a record of the hearing by a reporter present to make a record of the hearing or a recording of the proceedings. The cost of such reporter shall be borne by the Hospital, but copies of the transcript shall be provided to the practitioner requesting the hearing at that practitioner's expense. The hearing panel may, but shall not be required to, order that oral evidence shall be taken only on oath or affirmation administered by any person designated to administer such oaths and entitled to notarize documents in the State of Missouri.

6.5 Rights of the Practitioner and the Hospital

6.5.1 At the hearing both sides shall have the following rights, subject to reasonable limits determined by the presiding officer.

- a. To call and examine witnesses to the extent available;
- b. To introduce exhibits;
- c. To cross-examine any witness on any matter relevant to the issues and to rebut any evidence;
- d. To have representation by counsel who may be present at the hearing, the role of counsel will be determined at the pre-hearing conference. It will be either to:
 - i. Advise his or her client;
 - ii. Participate in resolving procedural matters; or to
 - iii. Argue the case for his or her client.Both sides shall notify the other of the name of their counsel at least ten (10) calendar days prior to the date of the hearing; and
- e. To submit a written statement at the close of the hearing.

6.5.2 Any practitioner requesting a hearing who does not testify in their own behalf may be called and examined as if under cross-examination.

6.5.3 The hearing panel may question the witnesses, call additional witnesses or request additional documentary evidence.

6.6 Admissibility of Evidence

The hearing shall not be conducted according to legal rules of evidence. Hearsay evidence shall not be excluded merely because it may constitute legal hearsay. Any relevant evidence shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law.

6.7 Burden of Proof

It is the burden of the MEC or Board to demonstrate that the action recommended is valid and appropriate. It is the burden of the practitioner under review to demonstrate that he or she satisfies, on a continuing basis, all criteria for initial appointment, reappointment, and clinical privileges and fully complies with all Medical Staff and Hospital policies/procedures.

6.8 Post-Hearing Memoranda

Each party shall have the right to submit a post-hearing memorandum and the hearing panel may request such a memorandum to be filed following the close of the hearing.

6.9 Official Notice

The presiding officer shall have the discretion to take official notice of any matters, either technical or scientific, relating to the issues under consideration. Participants in the hearing shall be informed of the matters to be officially noticed and such matters shall be noted in the record of the hearing. Either party shall have the opportunity to request that a matter be officially noticed or to refute the noticed matter by evidence or by written or oral presentation of authority. Reasonable additional time shall be granted, if requested by either party, to present written rebuttal of any evidence admitted on official notice.

6.10 Postponements and Extensions

Postponements and extensions of time beyond any time limit set forth in Part II of these Bylaws may be requested by anyone but shall be permitted only by the presiding officer or the CEO/President on a showing of good cause.

6.11 Persons to be Present

The hearing shall be restricted to those individuals involved in the proceeding. Administrative personnel may be present as requested by the CEO/President, or MEC.

6.12 Order of Presentation

The Board or the MEC, depending on whose recommendation prompted the hearing initially, shall first present evidence in support of its recommendation. Thereafter, the burden shall shift to the practitioner who requested the hearing to present evidence.

6.13 Basis of Recommendation

The hearing panel shall recommend in favor of whichever side demonstrates the preponderance of evidence.

6.14 Adjournment and Conclusion

The presiding officer may adjourn the hearing and reconvene the same at the convenience and with the agreement of the participants. Upon conclusion of the presentation of evidence by the parties and questions by the hearing panel, the hearing shall be closed.

6.15 Deliberations and Recommendation of the Hearing Panel

Within twenty (20) calendar days after final adjournment of the hearing, the hearing panel shall conduct its deliberations outside the presence of any other person (except the presiding officer, if one is appointed) and shall render a recommendation, accompanied by a report, which shall contain the reasons for the recommendation.

6.16 Disposition of Hearing Panel Report

The hearing panel shall deliver its report and recommendation to the CEO/President who shall forward it, along with all supporting documentation, to the Board for further action. The CEO/President shall also send a copy of the report and recommendation, certified mail, return receipt requested, to the practitioner who requested the hearing, and to MEC for information and comment.

Section 7. Appeal to the Board

7.1 Time for Appeal

Within ten (10) calendar days after the hearing panel makes a recommendation, either the practitioner subject to the hearing or the MEC may appeal the recommendation. The request for appellate review shall be in writing, and shall be delivered to the CEO/President either in person or by certified mail, and shall include a brief statement of the reasons of the appeal and the specific facts or circumstances which justify further review. If such appellate review is not requested within ten (10) calendar days as provided herein, both parties shall be deemed to have accepted the recommendation involved, and the hearing panel's report and recommendation shall be forwarded to the Board for final action.

7.2 Grounds for Appeal

The grounds for appeal shall be limited to the following:

- a. There was substantial failure to comply with the Medical Staff Bylaws prior to or during the hearing so as to deny a fair hearing;
- b. The recommendation of the hearing panel was made arbitrarily, capriciously or with prejudice; or
- c. The recommendation of the hearing panel was not supported by substantial evidence based upon the hearing record.

7.3 Time, Place and Notice

Whenever an appeal is requested as set forth in the preceding sections, the Chair of the Board shall schedule and arrange for an appellate review as soon as arrangements can be reasonably made, taking into account the schedules of all individuals involved. The affected practitioner shall be given notice of the time, place and date of the appellate review. The Chair of the Board may extend the time for appellate review for good cause.

7.4 Nature of Appellate Review

- 7.4.1 The Chair of the Board shall appoint a review panel composed of at least three (3) members of the Board to consider the information upon which the recommendation before the Board was made. Members of this review panel may not be direct competitors of the practitioner under review and should not have participated in any formal investigation leading to the recommendation for corrective action that is under consideration.
- 7.4.2 The review panel may, but is not required to, accept additional oral or written evidence subject to the same procedural constraints in effect for the hearing panel or hearing officer. Such additional evidence shall be accepted only if the party seeking to admit it can demonstrate that it is new, relevant evidence and that any opportunity to admit it at the hearing was denied. If additional oral evidence or oral argument is conducted, a record of this procedure, similar to that done for the hearing panel, will be made.
- 7.4.3 Each party shall have the right to present a written statement in support of its position on appeal. In its sole discretion, the review panel may allow each party or its representative to appear personally and make a time-limited thirty minute (30) oral argument. The review panel shall recommend final action to the Board.
- 7.4.4 The Board may affirm, modify or reverse the recommendation of the review panel or, in its discretion, refer the matter for further review and recommendation, or make its own decision based upon the Board's ultimate legal responsibility to grant appointment and clinical privileges.

7.5 Final Decision of the Board

Within thirty (30) calendar days after receiving the review panel's recommendation, the Board shall render a final decision in writing, including specific reasons for its actions, and shall deliver copies thereof to the affected practitioner and to the MEC, in person or by certified mail, return receipt requested.

7.6 Right to One Appeal Only

No applicant or Medical Staff member shall be entitled as a matter of right to more than one (1) hearing or appellate review on any single matter which may be the subject of an appeal. In the event that the Board ultimately determines to deny Medical Staff appointment, reappointment and/or clinical privileges to an applicant, or to revoke or terminate Medical Staff appointment and/or clinical privileges of a current member, that practitioner may not apply within five (5) years for Medical Staff appointment or for those clinical privileges at this Hospital unless the Board advises otherwise.

Section 8. Adoption and Approval

The Medical Staff Bylaws of Mercy Hospital Joplin have been approved and adopted as listed below:
06/25/2012 Board



MERCY HOSPITAL JOPLIN

MEDICAL STAFF BYLAWS

PART III: CREDENTIALS PROCEDURES MANUAL

November 7, 2014

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Exhibit H	Algorithm for Initial Appointment Process
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Exhibit K	Policy for Granting Permission to Practitioners to Provide Clinical Services to Patients at Mercy Hospital Joplin
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Exhibit O	Allied Health Professional Application for Recredentialing for Mercy Hospitals/Mercy Clinic/Mercy Health
Exhibit P	Allied Health Professional Review of Demographic Information
Exhibit Q	Application for Mercy Hospital Observer, Student or Medical Student Scope of Practice
Exhibit R	Mercy Joplin Community Application for Disaster Credentialing Allied Health Professionals

Exhibit S Request for Visiting Privileges – Mercy Hospitals
Exhibit T Mercy Health Springfield Community Application for Disaster Credentialing Physicians and
Advanced Practice Professionals

Section 1. Medical Staff Credentials Committee

1.1 Composition

Membership of the medical staff credentials committee shall consist of at least three (3) members of the active medical staff who are experienced leaders. The Vice Chief of Staff is the chair of the committee. The Chief of Staff will appoint members for three (3) year terms with the initial terms staggered such that approximately one-third (1/3) of the members will be appointed each year. The chair and members may be reappointed for additional terms without limit. Any member, including the chair, may be relieved of his or her committee membership by a two-thirds (2/3) vote of the Medical Executive Committee (MEC). The committee may also appoint members such as representatives from hospital administration and the Board.

1.2 Meetings

The medical staff credentials committee shall meet upon the call of the chair or Chief of Staff.

1.3 Responsibilities

- 1.3.1 To review and recommend action on all applications and reapplications for membership to the medical staff including assignments of medical staff category;
- 1.3.2 To review and recommend action on all requests regarding privileges from eligible practitioners;
- 1.3.3 To recommend eligibility criteria for granting of Medical Staff membership and clinical privileges;
- 1.3.4 To develop, recommend, and consistently implement policies/procedures for all credentialing and privileging activities;
- 1.3.5 To review, and when appropriate, take action on reports referred from other Medical Staff committees, Medical Staff or Hospital leaders; and
- 1.3.6 To perform such other functions as requested by the MEC.

1.4 Confidentiality

This committee shall function as a peer review committee consistent with federal and state law. All members of the committee shall, consistent with the medical staff and hospital confidentiality policies, keep in strict confidence all papers, reports, and information obtained by virtue of membership on the committee.

- 1.4.1 The credentials file is the property of the Hospital and will be maintained with strictest confidentiality and security. The files will be maintained by the designated agent of the Hospital in locked file cabinets or in secure electronic format. Medical Staff and administrative leaders may access credential files for appropriate peer review and institutional reasons. Files may be shown to accreditation and licensure agency representatives with permission of the Hospital CEO/President (or designee).
- 1.4.2 Individual practitioners may review their credentials file under the following circumstances:

- a. Only upon written request approved by the Chief of Staff or Hospital CEO/President. Review of such files will be conducted in the presence of the Medical Staff Services Professional, Medical Staff leader, or a designee of Administration. Confidential letters of reference may not be reviewed by practitioners and will be sequestered in a separate file and removed from the formal credentials file prior to review by a practitioner. Nothing may be removed from or copied from the file. The practitioner may make notes for inclusion in the file. A written or electronic record will be made and placed in the file confirming the dates and circumstances of the review.

Section 2. Qualifications for Medical Staff Membership and/or Privileges

- 2.1** No practitioner shall be entitled to membership on the Medical Staff or to clinical privileges merely by virtue of licensure, membership in any professional organization, or privileges at any other healthcare organization.
- 2.2** The following qualifications must be met by all applicants for Medical Staff appointment, reappointment, and/or clinical privileges;
 - 2.2.1 Demonstrate that he or she has successfully graduated from an approved school of medicine, osteopathy, dentistry or podiatry or applicable recognized course of training in a clinical profession eligible to hold privileges;
 - 2.2.2 Have a current unrestricted license as a practitioner, applicable to his or her profession and providing permission to practice within the State of Missouri.
 - 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 Possess a current, valid, unrestricted drug enforcement administration (DEA) number and Controlled Dangerous Substance (CDS) certification to prescribe controlled substances, if applicable;
 - 2.2.5 Have appropriate written and verbal communication skills;
 - 2.2.6 Have appropriate personal qualifications, including applicant's consistent observance of ethical and professional standards. These standards include, at a minimum;
 - a. Abstinance 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.
 - 2.2.7 Have a record that is free from current federal, state and/or healthcare agency sanctions or felony convictions (within the last ten (10) years), or as excluded by state law, or occurrences that would raise questions of undesirable conduct;
 - 2.2.8 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 board certified or become board

certified within five (5) years of completing formal training as defined by the appropriate specialty board of the American Board of Medical Specialties or the American Osteopathic Association. Maintenance of certification (if applicable) by the above board shall be required as of May 1, 2014;

- 2.2.9 Dentists must have graduated from an American Dental Association approved school of dentistry accredited by the Commission of Dental Accreditation and completed a Post-Graduate Specialty program, General Residency or Rotating Internship program. Maintenance of certification (if applicable) by the above board shall be required as of May 1, 2014;
- 2.2.10 Oral and maxillofacial surgeons must have graduated from an American Dental Association approved school of dentistry accredited by the Commission of Dental Accreditation and successfully completed an American Dental Association approved residency program and be board certified or become board certified within five (5) years of completing formal training as defined by the American Board of Oral and Maxillofacial Surgery. Maintenance of certification (if applicable) by the above board shall be required as of May 1, 2014; and
- 2.2.11 A podiatric physician, DPM, must have successfully completed a two (2) year residency program in surgical, orthopedic or podiatric medicine approved by the Council on Podiatric Medical Education of the American Podiatric Medical Association (APMA) and be board certified or become board certified within five (5) years of completing formal training as determined by the American Board of Podiatric Surgery or the American Board of Podiatric Orthopedics and Primary Podiatric Medicine. Maintenance of certification (if applicable) by the above board shall be required as of May 1, 2014;

2.3 The following qualifications must also be met by all applicants requesting clinical privileges:

- 2.3.1 Demonstrate his or her background, experience, training, current competence, knowledge, judgment and ability to perform all privileges requested;
- 2.3.2 Upon request provide evidence of both physical and mental health that does not impair the fulfillment of his or her responsibilities of Medical Staff membership and the specific privileges requested by and granted to the applicant;
- 2.3.3 Demonstrate recent clinical performance within the last twelve (12) months with an active clinical practice in the area in which clinical privileges are sought adequate to meet current clinical competence criteria;
- 2.3.4 Provide evidence of skills to provide a type of service that the Hospital Board of Directors have determined to be appropriate for the performance within the Hospital and for which a need exists;
- 2.3.5 Provide evidence of professional liability insurance with limits of one million dollars (\$1,000,000.00) per occurrence and three million dollars (\$3,000,000.00) in the aggregate; and
- 2.3.6 Demonstrate the capability to provide continuous care by residing and practicing within a geographical area which permits a response time which is timely and appropriate for his or her patient care activity and must provide evidence of acceptable physician coverage for patient care to MEC. The Hospital Rules and Regulations provide additional call schedule response time requirements.

2.4 Exceptions

- 2.4.1 All practitioners who are current Medical Staff members and/or held privileges as of January 1, 2012 and who have met prior qualifications for membership shall be exempt from board certification requirements.
- 2.4.2 Only Mercy Hospital Joplin Board of Directors may create additional exceptions to the above Section 2.2 after a joint conference with the MEC.

Section 3. Initial Appointment Procedure

3.1 Completion of Application

- 3.1.1 All requests for applications for appointment to the Medical Staff and requests for clinical privileges will be forwarded to Mercy Hospital Joplin Medical Staff Services. (*See Exhibit A: "Mercy Hospital Joplin Medical Staff Credentials Process Overview"*). Upon receipt of a request for an application, Medical Staff Services will provide the applicant with an application package. This package will enumerate the eligibility requirements for Medical Staff membership and/or privileges and a list of expectations of performance for individuals granted Medical Staff membership or privileges (if such expectations have been adopted by the Medical Staff). A complete set or overview of Medical Staff Bylaws of Mercy Hospital Joplin, rules and regulations, and policies and procedures or reference to an electronic source will be provided for this information.

A completed application includes, at a minimum:

- a. A completed, signed, dated application form;
- b. A completed privilege delineation form if requesting privileges;
- c. Copies of all requested documents and information necessary to confirm the applicant meets criteria for membership and/or privileges and to establish current competency;
- d. All applicable fees;
- e. A current picture ID card issued by a state or federal agency (e.g. driver's license or passport);
- f. Receipt of all references; references shall come from peers knowledgeable about the applicant's experience, ability and current competence to perform the privileges being requested;
- g. Relevant practitioner specific data as compared to aggregate data, when requested, and;
- h. Morbidity and mortality data, when requested.

An application shall be deemed incomplete if any of the above items are missing or if the need arises for new, additional, or clarifying information in the course of reviewing an application. An incomplete application will not be processed and the applicant will not be entitled to a fair hearing. Anytime in the credentialing process it becomes apparent that an applicant does not meet all eligibility criteria for membership or privileges, the credentialing process will be terminated and no further action taken.

- 3.1.2 The burden is on the applicant to provide all required information. It is the applicant's responsibility to ensure that Medical Staff Services receives all required supporting documents

verifying information on the application and to provide sufficient evidence, as required at the sole discretion of the Hospital, that the applicant meets the requirements for Medical Staff membership and/or privileges requested. If information is missing from the application, or new, additional or clarifying information is required, a letter requesting such information shall be sent to the applicant. If the requested information is not returned to Medical Staff Services within thirty (30) calendar days of the receipt of the request letter, the application will be deemed to have been voluntarily withdrawn.

- 3.1.3 Upon receipt of a completed application, the credentials committee chair (or designee), in collaboration with Medical Staff Services will determine if the requirements of Section 2.2 and 2.3 are met. In the event the requirements of those sections are not met the applicant will be notified that he or she is ineligible for membership on the Medical Staff or clinical privileges, the application will not be processed and the applicant will not be eligible for a fair hearing. If the requirements of Section 2.2 and 2.3 are met, the application will be accepted for further processing.
- 3.1.4 Individuals seeking appointment shall have the burden of producing information deemed adequate by the Hospital for a proper evaluation of current competence, character, ethics, and other qualifications and of resolving any doubts.
- 3.1.5 Upon receipt of a completed application, Medical Staff Services will verify current licensure, education, relevant training, and current competence from the primary source whenever feasible, or from a credentials verification organization (CVO). When it is not possible to obtain information from the primary source, reliable secondary sources may be used if there has been a documented attempt to contact the primary source. In addition, Medical Staff Services will collect relevant additional information which may include:
- a. Information from all prior and current liability insurance carriers concerning claims, suits, settlements and judgments during the past five (5) years;
 - b. Documentation of the applicant's past clinical work experience and other work experience if requested;
 - c. Licensure status in all current or past states of licensure at the time of initial granting of membership or privileges; in addition, Medical Staff Services will primary source verify licensure at the time of renewal or revision of clinical privileges, whenever a new privilege is requested, and at the time of license expiration;
 - d. Information from the AMA or AOA Physician Profile, and OIG List of Excluded Individuals/Entities, and the Missouri Opt Out listing;
 - e. Information from professional training programs including residency and fellowship programs;
 - f. Information from the National Practitioners Data Bank (NPDB); in addition, the NPDB will be queried at the time of renewal of privileges and whenever a new privilege(s) is requested;
 - g. Other information about adverse credentialing and privileging decisions;
 - h. Two (2) or more peer recommendations, as selected by the credentials committee and/or MEC, chosen from practitioners who have observed the applicant's clinical and professional performance and can evaluate the applicant's current medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, and professionalism as well as the physical, mental and emotional ability to perform requested privileges;
 - i. Information from a criminal background check;

- j. Information from any other sources relevant to the qualifications of the applicant to serve on the Medical Staff and/or hold privileges;
- k. Morbidity and mortality data and relevant practitioner-specific data as compared to aggregate data, when available; and
- l. If available and not legally protected, the results of any drug testing and/or other health testing required by a health care institution or licensing board.

3.1.6 In the event there is undue delay in obtaining required information, Medical Staff Services will request assistance from the applicant. During this time period, the “time periods for processing” the application will be appropriately modified. Failure of an applicant to adequately respond to a request for assistance after thirty (30) calendar days will be deemed a withdrawal of the application.

3.1.7 When the items identified in Section 3.1 above have been obtained, the file will be considered verified and complete and eligible for evaluation.

3.2 Applicant’s Attestation, Authorization and Acknowledgement

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

3.2.1 Attests to the accuracy and completeness of all information on the application or accompanying documents and agreement that any inaccuracy, omission, or misrepresentation, whether intentional or not, will be grounds for termination of the application process without the right to a fair hearing or appeal. If the inaccuracy, omission or misstatement is discovered after an individual has been granted appointment and/or clinical privileges, the individual’s appointment and/or clinical privileges shall terminate immediately upon notification of the individual without the right to a fair hearing or appeal.

3.2.2 Consents to appear for any requested interviews in regard to his or her application.

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

3.2.4 Consents to the Hospital and Medical Staff representatives’ inspection of all records and documents that may be material to an evaluation of his or her:

- a. Professional qualifications and competence to carry out the clinical privileges requested;
- b. Physical and mental/emotional health status to the extent relevant to safely perform privileges requested;
- c. Professional and ethical qualifications;
- d. Professional liability actions including currently pending claims involving the applicant; and
- e. Any other issue to establishing the applicant’s suitability for membership and/or privileges.

3.2.5 Releases from liability, promises not to sue and grants immunity to the Hospital, the Medical Staff, and its representatives for acts performed and statements made in connection with

evaluation of the application and his or her credentials and qualifications to the fullest extent permitted by the law.

- 3.2.6 Releases from liability and promises not to sue, all individuals and organizations who provide information to the Hospital or the Medical Staff, including otherwise privileged or confidential information to Mercy Hospital Joplin representatives concerning his or her background; experience; competence; professional ethics; character; physical and mental health to the extent relevant to the capacity to fulfill requested privileges; emotional stability; utilization practice patterns; and other qualifications for staff appointment and clinical privileges.
- 3.2.7 Authorizes Mercy Hospital Joplin Medical Staff and Mercy Hospital Joplin representatives to release any and all credentialing and peer review information to other hospitals, medical associations, licensing boards, appropriate government bodies and other health care entities or to engage in any valid discussion relating to the past and present evaluation of the applicant's training, experience, character, conduct, judgment and other matters relevant to the determination of the applicant's overall qualifications upon appropriately signed release of information document(s). Acknowledges and consents to agree to an absolute and unconditional release of liability and waiver of any and all claims, lawsuits or challenges against any Medical Staff or Hospital representative regarding the release of any requested information and further, that all such representatives shall have the full benefit of this release and absolute waiver as well as any legal protections afforded under the law. For the purposes of this provision, the term "Mercy Hospital Joplin representatives" includes Mercy Hospital Joplin Board of Directors and , their directors and committees, the Hospital CEO/President (or designee), registered nurses and other employees of Mercy Hospital Joplin , and the Mercy Hospital Joplin Medical Staff organization.
- 3.2.8 Acknowledges that the applicant has had access to the Medical Staff Bylaws, including all Rules and Regulations, policies/procedures of the Medical Staff must agree to abide by their provisions.

Notwithstanding Section 3.2.5 through 3.2.7, if an individual institutes legal action and does not prevail, he or she shall reimburse the Hospital and any member of the Medical Staff named in the action for all costs incurred in defending such legal action, including reasonable attorney(s) fees.

- 3.2.9 Agrees to provide accurate answers to the following questions and agrees to immediately notify the Hospital in writing should any of the information regarding these items change during processing of this application or the period of the applicant's Medical Staff membership or privileges. If the applicant answers any of the following questions affirmatively and/or provides information identifying a problem with any of the following items, the applicant will be required to submit a written explanation of the circumstances involved.
- a. Have any disciplinary actions been initiated or are any pending against you by any state licensure board?
 - b. Has your license to practice, registration, certification, or authority to practice in your profession ever been voluntarily or involuntarily relinquished, denied, limited, suspended, revoked, restricted, or have you ever been subject to a fine, reprimand, consent order, probation or any conditions or limitations by any state or professional licensing registration or certification board?
 - c. Have there been any investigations or challenges to your licensure, registration or authority to practice?
 - d. Have you ever been asked to surrender your professional license registration?

- e. Has your employment, clinical privileges or medical staff membership at any hospital or healthcare institution, voluntarily or involuntarily, ever been reduced, diminished, denied, suspended, revoked, restricted, refused, denied renewal or subject to probationary or to other disciplinary conditions (for reasons other than non-completion of medical record when quality of care was not adversely affected) or have proceedings toward any of those ends been instituted or recommended by any hospital or healthcare institution, medical staff or committee, or governing board?
- f. Have you ever withdrawn your application for appointment, reappointment, or clinical privileges or resigned from the Medical Staff before a hospital's or health facility's Board made a decision?
- g. Have you ever been the subject of a formal or information disciplinary or corrective action investigation?
- h. Have you ever been the subject of an investigation because of inappropriate conduct, disruptive behavior, or unprofessional actions (e.g. sexual harassment)?
- i. Have you ever been the subject of focused individual monitoring at any hospital or healthcare facility other than to confirm competency immediately following an initial grant of privilege(s)?
- j. If you are not currently board certified, please answer k. through n. below (if board certified, please skip to o. below).
- k. Have you ever been examined by any specialty board but failed to pass the examination? Please provide details.
- l. If not certified, have you applied for the certification exam?
- m. Have you ever been accepted to take the certification exam?
- n. If yes, what dates are you scheduled to take the certification exam?
- o. Have you voluntarily or involuntarily surrendered, limited your privileges or not reapplied for privileges while under investigation?
- p. Have you ever been terminated for cause or not renewed for cause from participation, or been subject to any disciplinary action by any managed care organizations (including HMOs, PPOs, or provider organizations such as IPAs, PHOs)?
- q. Were you ever placed on probation, disciplined, formally reprimanded, suspended or asked to resign during an internship, residency, fellowship, preceptorship or other clinical education program? If you are currently in a training program, have you ever been placed on probation, disciplined, formally reprimanded, suspended or asked to resign?
- r. Have you ever, while under investigation or to avoid an investigation, voluntarily withdrawn or prematurely terminated your status as a student or employee in any internship, residency, fellowship, preceptorship or other clinical education program?
- s. Have any of your board certifications or eligibility ever been revoked, denied, suspended, not renewed, denied renewal, or voluntarily or involuntarily surrendered?
- t. Have you ever chosen not to recertify or voluntarily surrendered your board certification(s) while under investigation?
- u. Have your Federal DEA and/or State Controlled Dangerous Substances (CDS) certificate(s) or authorization(s) ever been challenged, limited, denied, suspended, revoked, restricted, denied renewal, placed on probation, reprimand, or voluntarily or involuntarily relinquished?
- v. Is your DEA and/or CDS certificate currently being challenged?
- w. Have you ever been disciplined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, fined, disqualified or otherwise restricted in regard to participation in the Medicare or Medicaid program, or in regard to other federal or state governmental healthcare plans or programs?

- x. If you are practicing in Missouri, are you currently listed on the Missouri Employee Disqualification list?
- y. Are you currently the subject of an investigation by any hospital, licensing authority, DEA or CDS authorizing entities, education or training program, Medicare or Medicaid program, or any other private, federal or state health program or a defendant in any civil action that is reasonably related to your qualifications, competence, functions, or duties as a medical professional for alleged fraud, an act of violence, child abuse or a sexual offense or sexual misconduct?
- z. To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank;
- aa. Have you ever received sanctions from or are you currently the subject of an investigation by any regulatory agencies (e.g. CLIA, OSHA, etc.)?
- bb. Have you ever been convicted of, pled guilty to, pled nolo contendere to, sanctioned, reprimanded, restricted, disciplined or resigned in exchange for no investigation or adverse action for sexual harassment or other illegal misconduct?
- cc. Are you currently being investigated or have you ever been sanctioned, reprimanded, or cautioned by a military hospital, facility, or agency, or voluntarily terminated or resigned while under investigation or in exchange for no investigation by a hospital or healthcare facility of any military agency?
- dd. Has your professional liability coverage ever been cancelled, restricted, declined or not renewed by the carrier based on your individual liability history?
- ee. Have you ever been assessed a surcharge, or rated in a high-risk class for your specialty, by your professional liability insurance carrier, based on your individual liability history?
- ff. Have any professional liability claims or suits ever been filed against you or are any presently pending?
- gg. Have any judgments or settlements been made against you in professional liability cases? (If yes, please provide a short synopsis of the allegations and outcome of the case).
- hh. Have you ever been refused or denied coverage, had coverage cancelled, or had specific privileges excluded by a malpractice liability carrier?
- ii. Have you ever entered into an agreement with the federal or state government as a result of violations of state or federal regulations or law (e.g. a corporate integrity agreement)?
- jj. Have you ever been convicted of, plead guilty to, or pled nolo contendere to any felony?
- kk. Have you ever been convicted of, plead guilty to, or pled nolo contendere to any misdemeanor (excluding minor traffic violations) or been found liable or responsible for any civil offense that is reasonably related to your qualifications, competence, functions, or duties as a medical professional, or for fraud, an act of violence, child abuse or a sexual offense or sexual misconduct?
- ll. Have you ever been named as a defendant in any criminal proceedings or been arrested or charged with a crime?
- mm. Have you ever been court-martialed or other than honorably discharged from military service for actions related to your duties as a medical professional?
- nn. Are you currently engaged in the illegal use of drugs? ("Currently" means sufficiently recent to justify a reasonable belief that the use of drugs may have an ongoing impact on one's ability to practice medicine. It is not limited to the day of, or within a matter of days or weeks before the date of application, rather that it has occurred recently enough to indicate the individual is actively engaged in such conduct. "Illegal use of drugs" refers to drugs whose possession or distribution is unlawful under the Controlled Substances Act, 21 U.S.C. § 812.22. It "does not include the use of a drug taken under supervision by a licensed health care professional, or other uses authorized by the Controlled Substances

- Act or other provision of Federal law.” The term does include, however, the unlawful use of prescription controlled substances.)
- oo. Do you use any chemical substances or prescription medications that would in any way impair or limit your ability to practice medicine and perform the functions of your job with reasonable skill and safety?
 - pp. Have you ever been disciplined or formally reprimanded because of inappropriate conduct, disruptive behavior, or unprofessional interactions (e.g. sexual harassment)?
 - qq. Have you ever been terminated from employment or from a group practice?
 - rr. Do you have any reason to believe that you would pose a risk to the safety or well being of your patients?
 - ss. Are you unable to perform the essential functions of a practitioner in your area of practice even with reasonable accommodation?
 - tt. Are you currently enrolled or have been previously enrolled in any state Physicians’ Health Program?

3.3 Application Evaluation

3.3.1 Expedited Credentialing

An expedited review and approval process may be used for initial appointment. All initial applications for membership and/or privileges will be designated Category 1 or Category 2 as follows;

Category 1: A completed application that does not raise concerns as identified in the criteria for Category 2. Applicants in Category 1 will be granted medical staff membership and/or privileges after review and action by the following: department chair, credentials committee, the MEC and a Board committee consisting of at least two individuals. Only Category 1 Applicants are eligible for Temporary Privileges.

Category 2: If one or more of the following criteria are identified in the course of reviewing a completed and verified application, the application will be treated as Category 2. Applications in Category 2 must be reviewed and acted on by the department chair or Credentials Committee. If the file remains a Category 2 then it must be reviewed by the MEC, and the Board. The credentials committee may request that an appropriate subject matter expert assess selected applications. At all stages in this review process, the burden is upon the applicant to provide evidence that he or she meets the criteria for membership on the medical staff and for the granting of requested privileges. Category 2 applicants are not eligible for Temporary Privileges. Criteria for Category 2 applications include but are not necessarily limited to the following:

- a. The application is deemed to be incomplete;
- b. The final recommendation of the MEC is adverse or with limitation;
- c. The applicant is found to have experienced an involuntary termination of medical staff membership or involuntary limitation, reduction, denial, or loss of clinical privileges at another organization or has a current challenge or a previously successful challenge to licensure or registration;
- d. Applicant is, or has been, under investigation by a state medical board or has prior disciplinary actions or legal sanctions; to include public reprimand, suspension, probation, revocation;

- e. Applicant has had two (2) or more or an unusual pattern of malpractice cases filed within the past five (5) years or one final adverse judgment in a professional liability action [in excess of \$350,000];
- f. Applicant changed medical schools or residency programs or has gaps in training or practice;
- g. Applicant has changed practice affiliations more than three times in the past ten (10) years (unless they are a locums provider);
- h. Applicant has practiced or been licensed in three (3) or more states post residency/fellowship (unless they are a locums provider);
- i. Applicant has one or more reference responses that raise concerns or questions;
- j. Discrepancy is found between information received from the applicant and references or verified information;
- k. Applicant has an adverse National Practitioner Data Bank report within the last 5 years;
- l. The request for privileges are not reasonable based upon applicant's experience, training, and demonstrated current competence, and/or is not in compliance with applicable criteria;
- m. Applicant has been removed from a managed care panel for reasons of professional conduct or quality;
- n. Applicant has potentially relevant physical, mental and/or emotional health problems;
- o. Other reasons as determined by a medical staff leader or other representative of the hospital which raise questions about the qualifications, competency, professionalism or appropriateness of the applicant for membership or privileges;
- p. Applicant has had any previous or current issues related to drug or alcohol consumption.

3.4 Applicant Interview

3.4.1 All applicants for appointment to the Medical Staff and/or granting of clinical privileges may be required to participate in an interview at the discretion of the Department Chair, Credentials Committee, MEC, or Board. The interview may take place in person or by telephone as determined by the Department Chair, Credentials Committee, MEC, or Board. A permanent record of the interview will be documented using the **"Exhibit C: Mercy Hospital Joplin Interview Questionnaire"** incorporated herein as to solicit information required to complete the credentials file or clarify information previously provided, e.g. clinical knowledge and judgment, professional behavior, malpractice history, reasons for leaving past healthcare organizations, or other matters bearing on the applicant's ability to render care at the generally recognized level for the community. This interview may also be used to communicate Medical Staff performance expectations.

3.4.2 Procedure

The applicant will be notified if an interview is requested. It is the responsibility of the applicant to contact the responsible Medical Staff leader to arrange the interview. Failure of the applicant to schedule an interview with the designated Medical Staff leader within thirty (30) days will be deemed a withdrawal of the application.

3.5 Department Chair Action

3.5.1 All completed applications are presented to the department chair for review, and recommendation. The department chair reviews the application to ensure that it fulfills the established standards for membership and/or clinical privileges. The department chair, in

consultation with the medical staff professional, determines whether the application is forwarded as a Category 1 or Category 2. The department chair may obtain input if necessary from an appropriate subject matter expert. If a department chair believes a conflict of interest exists that might preclude his or her ability to make an unbiased recommendation he or she will notify the credentials chair and forward the application without comment.

3.5.2 The department chair forwards to the medical staff credentials committee the following:

- a. A recommendation as to whether the application should be acted on as a Category 1 or Category 2.
- b. A recommendation to approve the applicants request to membership and or privileges; to approve membership but modify the requested privileges or deny membership and or privileges; and
- c. A recommendation to define those circumstances which require monitoring and evaluation of clinical performance after initial grant of clinical privileges.
- d. Comments supporting the recommendations in 3.5.2 b above.

3.6 Medical Staff Credentials Committee Action

3.6.1 If the application is designated Category 1, it is presented to the credentials chair (or designee) for review and recommendation. The credentials chair reviews the application to ensure that it fulfills the established standards for membership and/or clinical privileges. The credentials chair has the opportunity to determine whether the application is forwarded as a Category 1 or may change the designation to a Category 2. If forwarded as a Category 1, the credentials chair acts on behalf of the medical staff credentials committee and the application is presented to the MEC for review and recommendation. If designated Category 2, the medical staff credentials committee review the application and forward the following to the MEC:

- a. A recommendation as to whether the application should be acted on as Category 1 or Category 2;
- b. A recommendation to approve the applicants request for membership and/or privileges; to approve membership but modify the requested privilege; or deny membership and/or privileges; and
- c. A recommendation to define those circumstances which require monitoring and evaluation of clinical performance after initial grant of clinical privileges.
- d. Comments supporting the recommendations in 3.6.1 b above.

3.7 MEC Action

3.7.1 If the application is designated Category 1, it is presented to the MEC where the application is reviewed to ensure that it fulfills the established qualifications and criteria for membership and/or clinical privileges. The Chief of Staff or the MEC has the opportunity to determine whether the application is forwarded as a Category 1, or may change the designation to a Category 2. If forwarded as a Category 1 the MEC acts and the application is forwarded to the Board:

- a. A recommendation as to whether the application should be acted on as a Category 1 or Category 2;
- b. A recommendation to approve the applicant's requests for membership and/or privileges; to approve membership but modify the requested privileges; or deny membership and/or privileges;

- c. A recommendation to define those circumstances which require monitoring and evaluation of clinical performance after initial grant of clinical privileges; and
- d. Comments supporting the recommendation in 3.7.1 b above.

Whenever the MEC makes an adverse recommendation to the board, a special notice, stating the reason, will be sent to the applicant who shall then be entitled to the procedural rights provided in Part II of these bylaws (Investigation, Corrective Action, Hearing and Appeal Plan).

3.8 Board Action

3.8.1 If the application is designated by the MEC as Category 1 it is presented to the Board or an appropriate subcommittee of at least two (2) members where the application is reviewed to ensure that it fulfills the established standards for membership and clinical privileges. If the Board or subcommittee agrees with the recommendation of the MEC, the application is approved and the requested membership and/or clinical privileges are granted for a period not to exceed twenty-four (24) months. If a subcommittee takes the action, it is reported to the entire Board at its next scheduled meeting. If the Board or subcommittee disagrees with the recommendation, then the procedure for processing a Category 2 application will be followed:

3.8.2 If the application is designated as a Category 2, the Board reviews the application and votes for one of the following actions;

- a. The board may adopt or reject in whole or in part a recommendation of the MEC or refer the recommendation to the MEC for further consideration stating the reasons for such referral back and setting a time limit within which a subsequent recommendation must be made.
- b. If the Board concurs with the applicants request for membership and/or privileges it will grant the appropriate membership and/or privileges for a period not to exceed twenty-four (24) months;
- c. If the Board's action is adverse to the applicant, a special notice, stating the reason, will be sent to the applicant who shall then be entitled to the procedural rights provided in Part II of these bylaws (Investigation, Corrective Action, Hearing and Appeal Plan); or
- d. The Board shall take final action in the matter as provided in Part II of these bylaws (Investigation, Corrective Action, Hearing and Appeal Plan).

3.9 Basis for Recommendation and Action

The report of each individual or group required to act on an application, including the Board, must state in writing the reasons for each recommendation or action taken, with specific reference to the completed application and all other documentation considered.

3.10 Conflict Resolution

Whenever the Board determines that it will decide a matter contrary to the MEC's recommendations, the matter will be submitted to a committee of equal members of the MEC and the Hospital Board for review and recommendation before the Board makes its final decision. The Board Chair shall be authorized to vote in order to break a tie. The committee will submit its recommendation to the Board within thirty (30) days of submission.

3.11 Notice of Final Decision

Notice of the Board's final decision shall be given, through its President to the MEC and will be communicated to appropriate Hospital patient-care area/departments. The applicant shall receive written notice of appointment and special notice of any adverse final decisions within sixty (60) days of the Board's final decision. A decision and notice of appointment includes the staff category to which the applicant is appointed, the department to which he or she is assigned, the clinical privileges he or she may exercise, the timeframe of the appointment and any special conditions attached to the appointment.

3.12 Time Periods for Processing

All individual and groups required to act on an application for staff appointment and/or clinical privileges must do so in a timely and good faith manner, and, except for good cause, each application will be processed within the following time periods:

- Medical Staff Services (to collect, verify and summarize) 90 days
- Department Chair (review and recommend) 15 days
- Credentials Committee (analyze and recommend) 30 days
- Medical Executive Committee (to reach final recommendation) 60 days
- Board of Directors (render final decision) 90 days.

These time periods are deemed guidelines and do not create any right to have an application processed within these precise periods. If the provisions of Part II of these Bylaws (Investigation, Corrective Action, Hearing and Appeal Plan) are activated, the time requirements provided therein govern the continued processing of the application.

Section 4. Professional Practice Evaluation

4.1 Focused Professional Practice Evaluation

All initially requested privileges shall be subject to a period of focused professional practice evaluation (FPPE). The Credentials Committee (after a recommendation from the department chair) and with the approval of the MEC will define the circumstances which require monitoring and evaluation of the clinical performance of each practitioner following his or her initial grant of clinical privileges at the Hospital. Such monitoring may utilize prospective, concurrent, or retrospective proctoring, including but not limited to: chart review, the tracking of performance monitors/indicators, external peer review, simulations, morbidity and mortality reviews, and discussion with other healthcare individuals involved in the care of each patient. The Credentials Committee will also establish the duration for such FPPE and triggers that indicate the need for performance monitoring.

4.2 Ongoing Professional Practice Evaluation

The Medical Staff will also engage in ongoing professional practice evaluation (OPPE) to identify professional practice trends that affect quality of care and patient safety. Information from this evaluation process will be factored into the decision to maintain existing privileges, to revise existing privileges, or to revoke an existing privilege prior to or at the time of reappointment. OPPE shall be undertaken as part of the Medical Staff's evaluation, measurement, and improvement of practitioner's current clinical competency. In addition, each practitioner may be subject to FPPE when issues affecting

the provision of safe, high quality patient care are identified through the OPPE process. Decisions to assign a period of performance monitoring or evaluation to further assess current competence must be based on the evaluation of an individual's current clinical competence, practice behavior, and ability to perform a specific privilege.

Section 5. Reappointment Procedure

5.1 Criteria for Reappointment

5.1.1 It is the policy of the Hospital to approve for reappointment and/or renewal of privileges only those practitioners who meet the criteria for initial appointment as identified in Section 2. The MEC must also determine that the practitioner provides effective care that is consistent with the Hospital standards regarding ongoing quality and the Hospital performance improvement program. The practitioner must provide the information enumerated in Section 5.2 below. All reappointment and renewals of clinical privileges are for a period not to exceed twenty-four (24) months. The granting of new clinical privileges to existing Medical Staff members will follow the steps described in Section 3 above concerning the initial granting of new clinical privileges and Section 4 above concerning focused professional practice evaluation. A suitable peer shall substitute for the department chair in the evaluation of current competency of the department chair and recommend appropriate action to the credentials committee.

5.2 Information Collection and Verification

5.2.1 Information from Appointee

On or before five (5) months prior to the date of expiration of a Medical Staff appointment or expiration of privileges, a representative from Medical Staff Services notifies the appointee of the date of expiration and supplies him or her with an application for reappointment for membership and/or privileges. At least sixty (60) calendar days prior to the date the appointee must return the following to Medical Staff Services (See Exhibit D: "Application for Reappointment Medical Staff Membership/Privileges/Mercy Hospital(s)"):

- a. A completed reapplication form, which includes complete information to update his or her file on items listed in his or her original application, any required new, additional, or clarifying information and any required fees or dues;
- b. Information concerning continuing training and education during the preceding period;
- c. Specific requests for clinical privileges sought on reappointment, with any basis for changes; and
- d. By signing the reapplication form, the appointee agrees to the same terms as identified in Section 3.2 above.

5.2.2 Internal and/or External Sources

Medical Staff Services collects from internal and/or external sources information regarding each staff appointee's professional and collegial activities to include those items listed in Section 3.2.9 items a – tt.

5.2.3 Information Collected and Verified

The following information is collected and verified:

- a. A summary of clinical activity at the Hospital for each appointee due for reappointment;
- b. Performance and conduct in the Hospital and other healthcare organizations in which the practitioner has provided any clinical care since the last reappointment, including patient care, medical clinical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and system-based practice;
- c. Attestation of any required hours, if any, of category one continuing medical education activities (proof of attendance and program content will be submitted upon request);
- d. All current licensure and/or certification status;
- e. Documentation of applicant's health status;
- f. Service on Medical Staff and Hospital committees, as required;
- g. Timely and accurate completion of medical records;
- h. Compliance with all Bylaws, Rules and Regulations, policies/procedures of the Hospital and Medical Staff;
- i. Any gaps in employment or practice since the previous appointment or reappointment;
- j. National Practitioner Data Bank query; and
- k. When sufficient peer review data is not available to evaluate competency, one or more peer recommendations as selected by the credentials committee chosen from practitioner(s) who have observed the applicant's clinical and professional performance and can evaluate the applicant's current medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills and professionalism as well as the physical, mental and emotional ability to perform requested privileges.

5.2.4 Failure to Provide Information

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

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

5.3.1 Expedited review of reappointment application will be categorized as described in Section 3.3.1 above.

5.3.2 Reappointment Application Review and Action

The reappointment application will be reviewed and acted upon as described in Sections 5.2.1 through 5.2.3 above. For the purpose of reappointment an "adverse recommendation" by the Board as used in Section 5 means a recommendation or action to deny reappointment, or to deny or restrict requested clinical privileges or any action which would entitle the applicant to a Fair Hearing under Part II of these Bylaws. The terms "applicant" and "appointment" as used in these sections shall be read respectively, as 'staff appointee' and "reappointment".

5.3.3 Criteria for Reappointment

Medical Staff Members with no clinical activity at the Hospital during a twenty-four (24) month reappointment period will be notified that due to their lack of clinical activity, the Medical Staff Member no longer meets criteria for Active Medical Staff membership and/or clinical privileges.

- a. The above-referenced clinical activity requirement may be waived if the Medical Staff member provides coverage for another Medical Staff member or practices a specialty determined to be needed by the Hospital. In this case, the practitioner would be required to provide a summary of clinical activity from another facility to Medical Staff Services for review by the Credentials Committee and MEC upon reappointment.
- b. The physician may re-apply at a later date should his or her practice pattern change.

Section 6. Clinical Privileges

6.1 Exercise of Clinical Privileges

A practitioner providing clinical services at the Hospital may exercise only those privileges granted to him or her by the Board or emergency privileges described herein. Privileges may be granted by the Board upon recommendation of the MEC to practitioners who are not members of the Medical Staff. Such individuals may be Advance Practice Registered Nurses (APRNs), Physician Assistants (PAs), physicians serving short locum tenens positions, or others deemed appropriate by the MEC and Board.

6.2 Privilege Requests

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

6.3 Basis for Privileges Determination

- 6.3.1 Requests for clinical privileges will be considered only when accompanied by evidence of education, training, experience and demonstrated current competence as specified by the Hospital in its Board approved criteria for clinical privileges and evaluated on the competencies that follow:
 - a. Patient Care: Practitioners are expected to provide patient care that is compassionate, appropriate and effective for the promotion of health, prevention of illness, treatment of disease, and care at the end of life.
 - b. Medical/Clinical Knowledge: Practitioners are expected to demonstrate knowledge of established and evolving biomedical, clinical and social sciences, and the application of this knowledge to patient care and education of patients, families, and other health care members.
 - c. Practice Based Learning and Improvement: Practitioners are expected to be able to use scientific evidence and methods to investigate, evaluate, and improve patient care practices.
 - d. Interpersonal and Communication Skills: Practitioners are expected to demonstrate interpersonal and communication skills that enable them to establish and maintain professional relationships with patients, families, and other health care members.

- e. Professionalism: Practitioners are expected to demonstrate behaviors that reflect a commitment to continuous professional development, ethical practice, an understanding and sensitivity to diversity, and a responsible attitude toward their patients, their profession and society.
- f. Systems-based Practice: Practitioners are expected to demonstrate both an understanding of the contexts and systems in health care and the ability to apply this knowledge to improve and optimize patient care.

6.3.2 The Hospital shall evaluate financial resources, space, equipment, trained staff and qualified coverage to support the type of privileges being requested.

6.3.3 Privileges for which no criteria has been established

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

- a. Review the community, patient and Hospital need for the privilege and reach agreement with Administration and the Board that the privilege is approved to be exercised at the Hospital;
- b. Review with the credentials committee the efficacy and clinical viability of the requested privilege and confirm that this privilege is approved for use in the setting-specific area of the Hospital by appropriate regulatory agencies (FDA, OSHA, etc.);
- c. Meet with Administration to ensure that the new privilege is consistent with the Hospital's mission, values, strategic, operating, capital information and staffing plans; and
- d. Work with Administration to ensure any/all exclusive contract issues, if applicable, are resolved in such a way to allow the new or cross-specialty privileges in question to be provided without violating the existing contract. Upon recommendation from the credentials committee or subject matter experts (as determined by the credentials committee), the MEC will formulate the necessary criteria and recommend these to the Board. Once objective criteria have been established, the original request will be processed as described herein. See Exhibit F: "Algorithm for Processing Applicant Privilege Requests" and Exhibit G: "Algorithm for Developing Privilege Criteria".

6.3.4 Privilege Criteria Development Process:

- a. For the development of criteria the Medical Staff Services Professional (or designee) will compile information relevant to the privileges requested which may include, but need not be limited to, position and opinion papers from specialty organizations, white papers from the Credentialing Resource Center and others as available, position and opinion statements from interested individuals or groups, and documentation from other hospitals in the region as appropriate.
- b. Criteria to be established for the privilege(s) in question include education, training, board status, or certification (if applicable), experience, and evidence of current competence. Proctoring requirements, if any, will be addressed including who may serve as proctor and how many proctored cases will be required. Hospital related issues such as exclusive contracts, equipment, clinical support staff and management will be referred to the appropriate hospital administrator and/or department director;

- c. If the privileges requested overlap two or more specialty disciplines, an ad hoc committee will be appointed by the Credentials Chair to recommend criteria for the privilege(s) in question. This committee will consist of at least one, but not more than two, members from each involved discipline. The chair of the ad hoc committee will be a member of the Credentials Committee who has no vested interest in the issue.

6.3.5 Privilege Request Evaluation

Requests for clinical privileges will be consistently evaluated on the basis of prior and continuing education, training, experience, utilization practice patterns, current ability to perform the privileges requested, and demonstrated current competence, ability, and judgment. Additional factors that may be used in determining privileges are patient care needs, the hospital's capability to support the type of privileges being requested and the availability of qualified coverage in the applicant absence. The basis for privilege determination is to be made in connection with periodic reappointment. A requested change in privileges must include documented clinical performance and results of the practitioner's performance improvement program activities. Privilege determination will also be based on pertinent information from other sources, such as peers and/or faculty from other institutions and health care settings where the practitioner exercises clinical privileges.

- 6.3.6 The procedure by which requests for clinical privileges are processed are as outlined in Section 3 of this manual.

6.4 Special Conditions for Dental Privileges

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

6.5 Special Conditions for Podiatric Privileges

Requests for clinical privileges for podiatrists are processed in the same manner as all other privilege requests. All podiatric patients will receive a basic medical evaluation (history and physical) by a physician member of the Medical Staff with privileges to perform such an evaluation, which will be recorded in the medical record. The basic medical evaluation (history and physical) can be performed by the podiatrist on their own patients. Podiatrist must provide documentation to verify with his/her residency that performing H & Ps was included in their training.

6.6 Special Conditions for Telemedicine Privileges

Telemedicine is the provision of clinical services to patients by physicians and/or advance practice professionals from a distance via electronic communications. The Hospital may make arrangements through written agreements either with a distant site hospital or a distant site telemedicine entity for the provision of telemedicine services. The telemedicine physicians and/or advance practice professional

provides clinical services to the Hospital either simultaneously or non-simultaneously. The clinical services contracted are consistent with commonly accepted quality standards.

- 6.6.1 Practitioners who are responsible for the patient's care, treatment and services via telemedicine link are credentialed and privileged to do so at the originating site through one of the following mechanisms.
- a. The originating site fully privileges and credentials the practitioner according to Section 3; or
 - b. The originating site privileges practitioners using information from the distant site if the distant site is a Joint Commission-accredited organization. The distant-site practitioner has a license that is issued or accepted by the state of Missouri; or
 - c. The originating site may choose to use the credentialing and privileging decision from the distant site to make a final privileging decision if all the following requirements are met:
 - i. The distant site is a Joint Commission-accredited hospital or ambulatory care organization.
 - ii. The practitioner is privileged at the distant site for those services to be provided at the originating site.
 - iii. The distant site provides the originating site with a current list of licensed independent practitioner's privileges.
 - iv. The originating site has evidence of an internal review of the practitioner's performance of these privileges and sends to the distant site information that is useful to assess the practitioner's quality of care, treatment, and services for use in privileging and performance improvement. At a minimum, this information includes all adverse outcomes related to sentinel events considered reviewable by the Joint Commission that result from the telemedicine services provided and complaints about the distant site licensed independent practitioner from patients, licensed independent practitioners or staff at the originating site.
 - v. The originating site must verify that the distant site made its decision at a minimum using The Joint Commission Standards and Medicare Conditions of Participation for credentialing and privileging of practitioners.
- 6.6.2 Originating Site is the site at which the patient is receiving care and the distant site is the site from which the prescribing or treating services are provided.
- 6.6.3 The practitioner must concurrently maintain privileges, at a minimum, for the same scope of services at the distant site hospital as he or she is requesting at the originating site hospital, when applicable. Distant site shall provide a copy of practitioner's(s) approved privileges.
- 6.6.4 Outcomes measurement of telemedicine program and practice will be evaluated to ensure clinical quality, efficiency, and patient satisfaction.

6.7 Special Conditions for Licensed Independent Practitioners and Advanced Practice Professionals Eligible for Privileges Without Membership

Requests for privileges from such individuals are processed in the same manner as requests for clinical privileges by practitioners eligible for Medical Staff membership, with the exception that such individuals are not granted membership on the Medical Staff and do not have the rights and privileges of such membership. Only those categories of practitioners approved by the Boards for patient care are eligible to apply for privileges. Advanced Practice Professionals (APP) in this category may, subject to any

licensure requirements or other limitations, exercise independent judgment only within the areas of their professional competence and participate directly in the medical management of patients under the supervision of a physician who has been accorded privileges to provide such care. The privileges of these APPs shall terminate immediately, without the right to due process, in the event that the employment of the APP with the Hospital is terminated for any reason or if the employment contract or sponsorship of the APP with a physician member of the Medical Staff is terminated for any reason. ***See Exhibit K: "Policy for Granting Permission to Practitioners to Provide Clinical Services to Patients at Mercy Hospital Joplin", Exhibit L: "Mercy Hospital Joplin Policy for the Granting of Privileges for Practitioners Not Eligible for Medical Staff Membership", and Exhibit M: "Mercy Hospital Joplin Administrative Policy for Dependent Allied Health Professional."***

6.8 Special Conditions for the Aging Practitioner

Please refer to Part IV: Organization and Functions Manual, Section 3.12.

6.9 Special Conditions for Residents or Fellows in Training

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

6.9.2 The post-graduate education program director must communicate periodically with the MEC and the Board about the performance of its residents, patient safety issues, and quality of patient care and must work with the MEC to assure that all supervising physicians possess clinical privileges commensurate with their supervising activities.

6.10 Special Conditions for Visiting Privileges

Visiting privileges may be granted in writing by the Chief of Staff and Hospital CEO/President to physicians attending MEC-approved Mercy Hospital Joplin –sponsored training, serving as a proctor to a Medical Staff member or observing a procedure.

6.10.1 Applicants for visiting privileges must meet the following requirements:

- a. Documentation of a license to practice medicine, dentistry, or podiatry in any State of the United States, unless applicant will perform a procedure which would require documentation of a license to practice medicine in the State of Missouri. (Non-US licensed practitioners must receive a special exception, on a case-by-case basis, to serve as a proctor);
- b. Documentation of the applicant's request, including the outline of procedures and techniques that the applicant will perform or demonstrate; the dates this activity will occur; and a statement from the applicant that he or she accepts all responsibility and

- liability for the procedures he or she performs within the scope of his or her visiting privileges;
- c. Fulfilled the training requirements, if applicable for the privileges requested, or hold granted privileges from a Joint Commission-accredited institution for the privilege(s) for which applicant is providing training/proctoring;
- d. Evidence of professional liability insurance in the amount required by these bylaws that covers his or her activities in the Hospital;
- e. Documentation of compliance with the Hospital's health screening requirements; and
- f. Completion of Visiting Privilege Application Form (***See Exhibit S, Request for Visiting Privileges - Mercy Hospital Joplin***), which includes the attestation questionnaire, authorization, release, confidentiality statement, professional liability questionnaire, and professional liability action information.

6.10.2 Visiting privileges may be granted only for a specified time frame and/or for a specific number of initial cases. Such privileges shall be restricted to the treatment of not more than three (3) patients in any one year by any such individuals unless an exception is requested. Visiting privileges may be terminated by the Chief of Staff at any time.

6.10.3 Visiting privileges shall be limited to the procedure specified in the applicant's request. At all times, an active member of the Medical Staff shall act as the patient's attending physician and retains ultimate authority and responsibility for the diagnosis or diagnoses and treatment in the care of the patient.

6.10.4 The applicant shall not be entitled to the procedural rights afforded by Part II (Investigations, Corrective Action, Hearing and Appeal Plan) because a request for visiting privileges is refused or because all or any portion of the visiting privileges are terminated or suspended.

6.10.5 All persons requesting or receiving visiting privileges shall be bound by the Medical Staff Bylaws and Rules and Regulations, policies/procedures of the Hospital.

6.11 Temporary Privileges

The Hospital CEO/President (or designee) acting on behalf of the Board and based on the recommendation of the Chief of Staff (or designee) or Department Chairman, may grant temporary privileges provided Medical Staff Services is able to verify the practitioner's current licensure and competence. Temporary privileges may be granted only in two (2) circumstances: 1) to fulfill an important patient care, treatment or service need or 2) when an initial applicant with a complete application is awaiting review and approval of the Credentials Committee, MEC and the Hospital Board.

6.11.1 Important Patient Care, Treatment or Service Need

Temporary privileges may be granted on a case-by-case basis when an important patient care, treatment, or service need exists that mandates an immediate authorization to practice, for a limited period of time, not to exceed one hundred and twenty (120) calendar days while the full credentials information is verified and approved. When granting such privileges Medical Staff Services verifies current licensure and current competence. For the purposes of granting temporary privileges, an important patient care, treatment or service need is defined as including the following:

- a. A circumstance in which one or more individual patients will receive care that does not adequately meet their clinical needs if the temporary privileges under consideration are not granted, (such as, a patient scheduled for urgent surgery who would not be able to undergo the surgery in a timely manner);
- b. A circumstance in which the Hospital will be placed at risk of not adequately meeting the needs of patients who seek care from the Hospital if the temporary privileges under consideration are not granted (such as, the Hospital will not be able to provide adequate emergency room coverage in the practitioner's specialty), or the Hospital Board has granted privileges involving new technology to a physician on the Hospital Medical Staff provided the physician is proctored for a specific number of initial cases and the proctoring physician, who is not seeking Medical Staff membership, requires temporary privileges to serve as a preceptor; and
- c. A circumstance in which a group of patients in the community will be placed at risk of not receiving patient care that meets their clinical needs if the temporary privileges under consideration are not granted, (such as, a physician who has a large practice in the community for which adequate coverage of hospital care for those patients cannot be arranged).

6.11.2 Clean Application Awaiting Approval

- a. Temporary privileges may be granted for up to one hundred and twenty (120) days when the new applicant for Medical Staff membership and/or privileges is awaiting review and recommendation for approval by the Credentials Committee, MEC and approval by the Board. Criteria for granting temporary privileges in these circumstances include the applicant providing evidence of the following which has been verified by Mercy Hospital Joplin Medical Staff Services: current licensure and status; education; training and experience; hospital membership and/or clinical privileges; current competence; current DEA (if applicable); current professional liability insurance in the amount required; malpractice history; two (2) positive references specific to the applicant's competence from an appropriate medical peer, ability to perform the privileges requested; a query to the OIG's List of Excluded Individuals/Entities, results from a query to the National Practitioner Data Bank, and results from a criminal background check. Additionally, the application must meet the criteria for Category I, expedited credentialing consideration as noted in Section 3.3 of this manual.
- b. Temporary privileges for practitioners with completed applications awaiting approval by the Credentials Committee, MEC and Board must be reviewed and recommended by the Department Chair, Chief of Staff and Hospital CEO/President (or designees).

6.11.3 Temporary privileges are not to be routinely used at reappointment or for other administrative purposes such as the following situations:

- a. The practitioner fails to provide all information necessary for the processing of his or her reappointment in a timely manner; or
- b. Failure of the staff to verify performance data and information in a timely manner.

6.11.4 Special requirements of consultation and reporting may be imposed as part of the granting of temporary privileges. Except in unusual circumstances, temporary privileges will not be granted unless the practitioner has agreed in writing to abide by the Medical Staff Bylaws, Rules and Regulations, and policies/procedures of the Medical Staff and Hospital in all matters relating to his or her temporary privileges. Whether or not such written agreement is obtained, these

Bylaws, Rules and Regulations, and policies/procedures control all matters relating to the exercise of clinical privileges.

6.11.5 Termination of Temporary Privileges

The Hospital CEO/President, acting on behalf of the Board and after consultation with the Chief of Staff, may terminate any or all of the practitioner's privileges based upon the discovery of any information or the occurrence of any event of a nature which raises questions about a practitioner's privileges. When a patient's life or wellbeing is endangered, any person entitled to impose summary suspension under the Medical Staff Bylaws may affect the termination. In the event of any such termination, the practitioner's patients will be assigned to another practitioner by the Hospital CEO/President (or designee). The wishes of the patient shall be considered, when feasible, in choosing a substitute practitioner.

6.11.6 Rights of the Practitioner with Temporary Privileges

A practitioner is not entitled to the procedural rights afforded in Part II of these Bylaws (Investigation, Corrective Action, Hearing and Appeal Plan) because his or her request for temporary privileges is refused or because all or any part of his or her temporary privileges are terminated or suspended unless the decision is based on clinical competence or unprofessional conduct.

6.11.7 Emergency Privileges

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

6.12 Disaster Privileges

6.12.1 If the Hospital's Emergency Management Plan has been activated, and the Hospital is unable to meet immediate patient needs, the Hospital CEO/President and such other individuals as identified in the Hospital's Emergency Management Plan with such authority, may, on a case-by-case basis consistent with medical licensing and other relevant state statutes, grant disaster privileges to provide patient care to selected volunteer practitioners. At a minimum, volunteer 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 hospital photo identification (ID) card that clearly identifies professional designation;
- b. A current medical license to practice;
- c. A primary source verification of medical licensure;
- 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), 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 current Hospital co-worker or Medical Staff member(s) who possess personal knowledge regarding volunteer practitioner's ability to provide care and services without direction during a disaster.
- 6.12.2 Each volunteer practitioner granted disaster privileges will be required to practice under the supervision of a designated member of the Medical Staff whose privileges at a minimum include the disaster privileges granted to the volunteer. The supervising Medical Staff member shall oversee the professional performance of volunteer practitioner(s) who have been granted disaster privileges by direct observation or clinical record review. Volunteer practitioners shall be identified in the hospital(s) according to the Emergency Management Plan.
- 6.12.3 The Hospital will seek to verify the volunteer practitioner's current license and current competency from information provided on "**Attachment T, Mercy Hospital Joplin Application for Disaster Credentialing Physicians and Mid-Level Practitioners.**" Primary source verification of licensure begins as soon as the immediate situation is under control, and is completed within seventy-two (72) hours from the time the volunteer practitioner presents to the Hospital. In the extraordinary circumstance that primary source verification cannot be completed in seventy-two (72) hours (e.g., no means of communication or a lack of resources), it is expected that it be done as soon as possible. In this extraordinary circumstance, there must be documentation of the following:
- a. Reason primary source verification could not be performed in the required time frame;
 - b. Evidence of the volunteer practitioner's demonstrated ability to continue to provide adequate care, treatment, and services; and
 - c. Attempt to rectify the inability to perform source verification as soon as possible.
- 6.12.4 Continuation of the disaster privileges initially granted to volunteer practitioners shall be approved by the Hospital based on information obtained regarding the professional performance of the volunteer practitioner within seventy-two (72) hours.
- 6.12.5 Once the immediate situation has passed and such determination has been made consistent with the Hospital's Emergency Management Plan, the volunteer practitioner's disaster privileges will terminate immediately.
- 6.12.6 Any individual identified in the Hospital's Emergency Management 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 of a fair hearing or an appeal.

Section 7. Completion of History and Physical Examination

- 7.1** A medical history and physical examination must be completed no more than thirty (30) days before or within 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, or other qualified licensed individual in accordance with State law and Hospital policy.

- 7.2** An updated examination of the patient, including any changes in the patient's condition, must be completed and documented within twenty-four (24) after admission or registration, but prior to surgery or a procedure requiring anesthesia services, when the medical history and physical examination are 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, or other qualified licensed individuals in accordance with State law and Hospital policy. If Anesthesia has assessed this patient prior to a procedure, this assessment may serve as the update to the history and physical examination.
- 7.3** The content of complete and focused history and physical examination is delineated in the Medical Staff Rules and Regulations.

Section 8. Preceptorship

- 8.1** A practitioner who has not provided acute inpatient care for the past two (2) years or more who requests clinical privileges at a Hospital must arrange for a preceptorship either with a current member in good standing of the Medical Staff who practices in the same specialty or with a training program or other equivalently competent physician practicing outside of the Hospital. The practitioner must assume responsibility for any financial costs required to fulfill the requirements of Sections 8.1 and 8.2.
- 8.2** A description of the preceptorship program including details of monitoring and consultation must be written and submitted for approval to the Department Chair, Credentials Committee and MEC. At a minimum, the preceptorship program description must include the following:
- 8.2.1 The scope and intensity of required preceptorship activities; and
- 8.2.2 The requirement for submission of a written report from the preceptor prior to termination of the preceptorship period assessing at a minimum, the applicant's demonstrated clinical competence related to the privileges requested, ability to get along with others, the quality and timeliness of medical record documentation, ability to perform the privileges requested, and professional ethics and conduct.

Section 9. Reapplication and Modification of Membership Status or Privileges and Exhaustion of Remedies

9.1 Reapplication After Adverse Credentials Decision

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

9.2 Reapplication After Administrative Revocation

A practitioner who has had his or her appointment or clinical privileges administratively revoked for failure to maintain current Missouri state medical licensure, current professional liability insurance in the specified amount, failure to maintain and complete medical records, or any other responsibility of a Medical Staff member may reapply for Medical Staff membership and/or privileges as an initial applicant and will be reinstated for appointment and appropriate privileges upon submission of documentation that he or she has resolved the reason for the revocation.

9.3 Requests for Modification of Appointment Status or Privileges

A staff appointee, either in connection with reappointment or at any other time, may request modification of staff category or clinical privileges by submitting a written request to Medical Staff Services. A modification request must be on the prescribed form, "Exhibit E: Request for Modification of Hospital Privileges/Change in Medical Staff Category/Return from Leave of Absence," and must contain all pertinent information supporting the request. All requests for additional clinical privileges must be accompanied by information demonstrating additional education, training, and current clinical competence in the specific privileges requested. A modification application is processed in the same manner as a reappointment, which is outlined in Section 5 of this manual. A practitioner who determines that he or she no longer exercises, or wishes to restrict or limit the exercise of, particular privileges that he or she has been granted shall send written notice, through Medical Staff Services, to the Credentials Committee and MEC. A copy of this notice shall be included in the practitioner's credentials file. Revisions to, revocations of, or relinquishment of clinical privileges will be communicated to appropriate Hospital patient-care areas/departments.

9.4 Resignation of Staff Appointment or Privileges

A practitioner who wishes to resign his or her staff appointment and/or clinical privileges must provide written notice to the appropriate Department Chair or Chief of Staff. The resignation shall specify the reason for the resignation and the effective date. A practitioner who resigns his or her staff appointment and/or clinical privileges is obligated to fully and accurately complete all portions of all medical records for which he or she is responsible prior to the effective date of resignation. Failure to do so shall result in an entry in the practitioner's credentials file acknowledging the resignation and indicating that it became effective under unfavorable circumstances and shall be considered a matter of professional conduct that could adversely affect the health or welfare of a patient and so is reportable to the National Practitioner Data Bank, pursuant to the HCQIA (Health Care Quality Improvement Act) of 1986.

9.5 Exhaustion of Administrative Remedies

Every practitioner agrees that he or she will exhaust all the administrative remedies afforded in the various sections of these Bylaws and the Investigations, Corrective Action, Hearing and Appeal Plan before initiating legal action against the Hospital or its agents.

9.6 Reporting Requirements

The Hospital CEO/President (or designee) and Mercy's Legal Counsel shall be responsible for assuring that the Hospital satisfies its obligations under the Health Care Quality Improvement Act of 1986 and its successor statutes and any state reporting requirements. Actions that must be reported include any negative professional review action against a physician related to clinical incompetence or misconduct that leads to a denial of appointment and/or reappointment; reduction in clinical privileges greater than

thirty (30) days; resignation, surrender of privileges, or acceptance of privilege reduction either during investigation or to avoid an investigation.

Section 10. Leave of Absence

10.1 Leave Request

A practitioner may obtain a voluntary leave of absence by providing written notice to the MEC. The notice must state the reasons for the leave and approximate period of time of the leave, which may not exceed two (2) years except for military service or with expressed permission by the Board. While on leave of absence, the practitioner may not exercise clinical privileges or prerogatives and has no obligation to fulfill Medical Staff responsibilities. In the event that a practitioner has not demonstrated good cause for a leave, or where a request for extension is not granted, the determination shall be final, with no recourse to a hearing and appeal.

10.2 Medical Leave of Absence

A practitioner requesting to be excused from Medical Staff responsibilities and/or patient care for medical reasons must notify the Department Chair, Chief of Staff and/or Hospital CEO/President of the nature of the illness and the extent of the leave. The Chief of Staff and/or Hospital CEO/President may excuse the practitioner for medical reasons for a period of up to twenty-one (21) days. A leave of absence must be requested for any absence from the Medical Staff and/or patient care responsibilities greater than twenty-one (21) calendar days and whether such absence is related to the individual's physical or mental health or to the ability to care for patients safely and competently. The Chief of Staff and/or Hospital CEO/President will be responsible for notifying Medical Staff Services when a practitioner has been granted an excuse or leave of absence for medical reasons. Requests for leave must be forwarded with a recommendation from the MEC and affirmed by the Board.

In the instance of alcohol or substance abuse, a medical excuse or medical leave of any duration must be communicated to the Chief of Staff or Practitioner Health Committee who will be responsible for communicating it to the MEC. Prior to resuming his or her privileges and prerogatives, the practitioner will be required to submit a statement from the director of a treatment program documenting the practitioner's successful completion of the treatment program and enrollment in the Missouri Physicians' Health Program including monitored after care. The practitioner will also be requested to submit follow up reports regarding the progress of his or her rehabilitation.

If the situation arises whereby the Missouri Physicians' Health Program becomes inoperable or unable to deal with its stated mission, then the MEC shall have the discretion to institute an alternative program to monitor any instance of substance abuse to include drug screening and an aftercare program as deemed appropriate by the MEC.

10.3 Termination of Leave

At least thirty (30) calendar days prior to the termination of the leave, or at any earlier time, the practitioner may request reinstatement by sending a written notice to the Chief of Staff. The practitioner must submit a written summary of relevant activities during the leave and other information as requested by the MEC or Board. The MEC makes a recommendation to the Board concerning reinstatement, and the applicable procedures concerning the granting of privileges are followed. If the practitioner's current granting of membership and/or privileges is due to expire during the leave of absence, the practitioner

must apply for reappointment, or his or her appointment and/or clinical privileges shall lapse at the end of the appointment period.

10.4 Failure to Request Reinstatement

Failure, without good cause, to request reinstatement shall be deemed a voluntary resignation from the Medical Staff and shall result in automatic termination of membership, privileges and prerogatives. A member whose membership is automatically terminated shall not be entitled to the procedural rights provided in Part II of these Bylaws. A request for Medical Staff membership subsequently received from a member so terminated shall be submitted and processed in the manner specified for applications for initial appointments and/or clinical privileges.

Section 11. Practitioner Providing Contractual Services

11.1 When the Hospital contracts for patient care, treatment, and/or services rendered outside the Hospital but under the control of a Joint Commission-accredited organization, and these services are provided in part or in whole by a practitioner who provides official readings of images, tracings or specimens, one of the following mechanisms will be implemented:

11.1.1 The Hospital will specify in a contract that the contracting entity providing these services will ensure that all services provided by practitioners will be within the scope of his or her privileges granted at the contracting entity; and

11.1.2 The Hospital will verify that all practitioners providing services under the contract have privileges that include the services provided under the contract.

11.2 When the Hospital contracts for patient care, treatment, and/or services, rendered outside the Hospital but not under the control of a Joint Commission-accredited organization, and these services are provided in part or in whole by a practitioner who provides official readings of images, tracings or specimens, one of the following mechanisms in this manual.

11.2.1 The Hospital will specify in a contract that the entity providing these services by contract will ensure that all services provided by practitioners will be within the scope of his or her privileges granted at the contracting entity; or

11.2.2 The Hospital will verify that all practitioners providing services under the contract are privileged for the services provided under the contract through a copy of the practitioner's clinical privilege form.

11.3 Exclusivity Policy

Whenever Hospital policy specifies that certain hospital based facilities or services may be provided on an exclusive basis in accordance with contracts or letters of agreement between the Hospital and qualified practitioners, then other practitioners must, except in an emergency or life threatening situation, adhere to the exclusivity policy in arranging for or providing care. Application for initial appointment or for clinical privileges related to Hospital based facilities or services covered by exclusive agreements will not be accepted or processed unless submitted in accordance with the existing contract or agreement with the Hospital. Practitioners who have been previously been granted privileges, which then become

covered by an exclusive contract, will not be able to exercise those privileges unless they become a party to the contract.

11.4 Qualifications

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

11.5 Effect of Disciplinary or Corrective Action Recommended by the MEC

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

11.6 Effect of Contract or Employment Expiration or Termination

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

Section 12. Medico-Administrative Officers

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

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

12.3 Effect of Removal from Office or Adverse Change in Appointment Status

12.3.1 Where a contract exists between the Officer and the Hospital, its terms govern the effect of removal of the Medico-Administrative Officer's (Medical Director's) staff appointment and privileges and the effect of an adverse change in the Officer's staff appointment or clinical privileges on his or her remaining in office.

12.3.2 In the absence of a contract or where the contract is silent on the matter, removal from office has no effect on appointment status or clinical privileges. The effect of an adverse change in appointment status or clinical privileges on continuance in office will be as determined by the Hospital Board.

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

Section 13. Medical Staff Communication

- 13.1 Mercy Hospital Joplin requires all Medical staff members, advanced practice professionals and Allied Health Professional to maintain an active email address with Medical Staff Services and it should be read regularly.
- 13.2 Communication and emergent notifications will be sent via email.

Section 14. Adoption and Approval

The Medical Staff Bylaws of Mercy Hospital Joplin have been approved and adopted as listed below:
11/07/2014 Board



MERCY HOSPITAL JOPLIN

MEDICAL STAFF BYLAWS

PART IV: ORGANIZATION AND FUNCTIONS MANUAL

May 1, 2015

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Section 1. Organization and Functions of the Medical Staff

1.1 Organization of the Medical Staff

The Medical Staff shall be organized as a departmentalized staff to include Primary Care, Surgical Care, Specialty Care and Hospital Based Specialties. A department chair shall head each department with overall responsibility for the supervision and satisfactory discharge of assigned functions under the Medical Executive Committee (MEC). Clinical services are a method by which Mercy Hospital Joplin may organize its medical staff. Exhibit A contains a current listing of recognized Clinical Services which shall be updated from time to time.

1.2 Responsibilities for Medical Staff Functions

The organized Medical Staff is actively involved in the measurement, assessment, and improvement of the functions outlined in Section 1.3. The MEC is ultimately responsible for the oversight of Medical Staff functions. The MEC may create committees to perform certain prescribed functions. The Medical Staff Officers, Department Chairs, Hospital and Medical Staff Committee Chairs will work collaboratively to accomplish the required Medical Staff functions. This process may include periodic reports to the appropriate department or committee and elevating issues of concern to the MEC as needed to ensure adherence to regulatory/accreditation compliance and appropriate standards of medical care.

Additionally, Medical Staff Officers may appoint designated physician leaders to help fulfill Medical Staff functions and identify other medical and administrative resources needed to adequately fulfill these functions.

1.3 Description of Medical Staff Functions

The Medical Staff, acting as a whole or through a committee, is responsible for the following activities:

1.3.1 Governance, Direction, Coordination and Action

- a. Receive, coordinate and act upon, as necessary, the reports and recommendations from departments, committees, other groups, and officers concerning the functions assigned to them and the discharge of their delegated administrative responsibilities;
- b. Account to the Board and to the Medical Staff with written recommendations for the overall quality and efficiency of patient care at the Hospital;
- c. Participate in the coordination of care, treatment, and/or services with other practitioners and hospital personnel, as relevant to the care, treatment, and/or services of an individual patient (Organized Medical Staff);
- d. Take reasonable steps to maintain professional and ethical conduct, initiate investigations, and pursue corrective action of Medical Staff members, when warranted;
- e. Make recommendations on medical, administrative and hospital clinical and operational matters;

- f. Inform the Medical Staff of the accreditation program and the accreditation and state licensure status of the Hospital;
- g. Act on all matters of Medical Staff business, and fulfill any state and federal reporting requirements;
- h. Oversee, develop, and plan Continuing Medical Education plans, programs, and activities that are designed to keep the Medical Staff informed of significant new developments and new skills in medicine that are related to the findings of performance improvement activities;
- i. Provide education on current ethical issues, recommend ethics policies/procedures, develop criteria and guidelines for the consideration of cases having ethical implications, and arrange for consultation with concerned physicians when ethical conflicts occur in order to facilitate and provide a process for conflict resolution;
- j. Provide oversight concerning the quality of care provided by residents, interns, students, and ensure that the same act within approved guidelines established by the Medical Staff and Board; and
- k. Ensure effective, timely, and adequate comprehensive communication between the members of the Medical Staff and Medical Staff leaders as well as between Medical Staff leaders and Hospital Administration and the Board.

1.3.2 Medical Care Evaluation/Performance Improvement/Patient Safety Activities

- a. Perform ongoing professional practice evaluation (OPPE) and focused professional practice evaluations (FPPE) when concerns arise from OPPE based on the general competencies defined by the Medical Staff;
- b. Set expectations and define both individual and aggregate measures to assess current clinical competency, provide feedback to practitioners and develop action plans for improving the quality of clinical care provided;
- c. Be actively involved in the measurement, assessment and improvement of activities of practitioner performance that include but are not limited to the following:
 - Medical assessment and treatment of patients;
 - Use of medications;
 - Use of blood and blood components;
 - Operative and other procedures;
 - Education of patients and families;
 - Accurate, timely, and legible completion of patients' medical records to include the quality of medical histories and physical examination;
 - Appropriateness of clinical practice patterns;
 - Significant departures from established pattern of clinical performance;
 - Use of developed criteria for autopsies;
 - Sentinel event data;
 - Patient safety data;
 - Coordination of care, treatment and/or services with other practitioners and Hospital personnel, as relevant to the care, treatment, and/or services of an individual patient; or

- Findings of the assessment process relevant to individual performance.
- d. Committee findings, conclusions, recommendations and actions to improve the performance of practitioners to the Medical Staff leaders and the Board, and define in writing the responsibility for acting on recommendations for practitioners improvement.

1.3.3 Hospital Performance Improvement and Patient Safety Programs

- a. Understand the Medical Staff's and Administration's approach to and the methods of performance improvement;
- b. Assist the Hospital to ensure that important processes and activities to improve performance and patient safety are measured, assessed and spread systematically across all disciplines throughout the Hospital;
- c. Participate as requested in identifying and managing sentinel events and events that warrant intensive analysis; and
- d. Participate as requested in the Hospital's patient safety program including measuring, analyzing, and managing variation in the processes that affect patient care to help reduce medical/healthcare errors.

1.3.4 Information Management

- a. Review and evaluate medical records to determine that they:
 - Properly describe the condition and progress of the patient, the quality of medical histories and physical examinations, the therapy, the tests provided along with the results thereof, and the identification of responsibility for all actions taken; and
 - Are sufficiently complete at all times so as to facilitate continuity of care and communication between all those providing patient care services in the Hospital.
- b. Develop, review, enforce, and maintain surveillance at least quarterly over enforcement of Medical Staff and Hospital policies/procedures and rules relating to medical records including completion, preparation, forms, format, filing, indexing, storage, destruction, and availability; and recommend methods of enforcement thereof and changes therein; and
- c. Provide liaison with Hospital administration, nursing service, and medical records professionals in the utilization of the Hospital on matters relating to medical records practices and information management planning.

1.3.5 Emergency Preparedness

Assist the Hospital Administration in developing, periodically reviewing, and implementing an emergency preparedness program that addresses disasters both external and internal to the Hospital.

1.3.6 Strategic Planning

- a. Participate in evaluating existing programs, services, and facilities of the Hospital and Medical Staff; and recommend continuation, expansion, abridgment, or termination of each;
- b. Participate in evaluating the financial, personnel, and other resource needs for beginning a new program or service, for constructing new facilities, or for acquiring new or replacement capital equipment; and assess the relative priorities or services, needs and allocation of present and future resources; and
- c. Communicate strategic, operational, capital, human resources, information management, and corporate compliance plans to Medical Staff members.

1.3.7 Medical Staff Bylaws Review

- a. Conduct periodic review of the Medical Staff Bylaws, Rules and Regulations and policies/procedures; and
- b. Submit written recommendations to the MEC and Board for amendments to the Medical Staff Bylaws, Rules and Regulations, and policies/procedures.

1.3.8 Nominating

- a. Identify nominees for election to the officer positions and to other elected positions in the Medical Staff organizational structure; and
- b. In identifying nominees, consult with members of the Medical Staff, the MEC, and Administration concerning the qualifications and acceptability of prospective nominees.

1.3.9 Infection Control Oversight

- a. The Medical Staff oversees the development and coordination of the Hospital-wide program for surveillance, prevention, implementation, and control of infection;
- b. Develop and approve policies/procedures describing the type and scope of surveillance activities including:
 - Review of cumulative microbiology identification and sensitivity reports;
 - Determination of definitions and criteria for healthcare acquired infections;
 - Review of prevalence and incidence studies, as appropriate; and
 - Collection of additional data as needed.
- c. Approve infection prevention and control actions based on evaluation of surveillance reports and other information;
- d. Evaluate, develop, and revise a surveillance plan for all sampling of personnel and environments annually;
- e. Develop procedures and systems for identifying, reporting, and analyzing the incidence and causes of infections;
- f. Institute any surveillance, prevention, and control measures or studies when there is reason to believe any patient or personnel may be at risk;

- g. Report healthcare acquired infection findings to the attending physician and appropriate clinical or Administrative leaders; and
- h. Review all policies/procedures on infection prevention, surveillance, and control at least biannually.

1.3.10 Pharmacy and Therapeutics Functions

- a. Maintain a formulary of drugs approved for use by the Hospital;
- b. Create treatment guidelines and protocols in cooperation with medical and nursing staff including review of clinical and prophylactic use of antibiotics;
- c. Monitor and evaluate the efforts to minimize drug misadventures (adverse drug reactions, medication errors, drug/drug interactions, drug/food interactions, and pharmacist interventions);
- d. Perform drug usage evaluation studies on selected topics;
- e. Perform medication usage evaluation studies as required by The Joint Commission;
- f. Perform practitioner profile analysis related to medication use;
- g. Approve policies/procedures related to the provision of care, treatment and services : to include the review of nutrition policies/procedures and practices, including guidelines/protocols on the use of special diets and total parenteral nutrition; pain management; procurement; storage; distribution; use; safety procedures; and other matters relating to medication use within the Hospital.;
- h. Develop and measure indicators for the following elements of the patient treatment functions:
 - Prescribing/ordering of medications;
 - Preparing and dispensing of medications;
 - Administering medications; and
 - Monitoring of the effects of the medication.
- i. Analyze and profile data regarding the measurement of the patient treatment functions by service and practitioner, where appropriate;
- j. Provide routine summaries of the above analysis and recommend process improvement when opportunities are identified;
- k. Serve as an advisory group to the Hospital and Medical Staff pertaining to the choice of available medications; and
- l. Establish standards concerning the use and control of investigational medication and of research in the use of recognized medication.

1.3.11 Practitioner Health

- a. Evaluate the credibility of a complaint, allegation or concern and establish a program for identifying and contacting practitioners, who have become professionally impaired in varying degrees, because of drug dependence (Including alcoholism) or because of mental, physical or aging problems. Refer the practitioner to appropriate professional internal or external resources for evaluation, diagnosis and treatment;

- b. Establish programs for educating practitioners and staff to prevent substance dependence and recognize impairment;
- c. Notify the impaired practitioner's department chair and the MEC whenever the impaired practitioner's actions could endanger patients. The existence of the Practitioner Health Committee does not alter the primary responsibility of the Department Chair for clinical performance within that chairs department;
- d. Create opportunities for referral (including self referral) while maintaining confidentiality to the greatest extent possible; and
- e. Reports to the MEC all practitioners providing unsafe treatment so that the practitioner can be monitored until his or her rehabilitation is complete and periodically thereafter. The Hospital shall not reinstate a practitioner until it is established that the practitioner has successfully completed a rehabilitation program in which the Hospital has confidence.

1.3.12 Credentials Review (see Part III. Credentials Procedure Manual)

1.3.13 All minutes and records reviewed will be maintained as a permanent record and will be kept in compliance with the confidentiality policies/procedures of the Medical Staff and the Hospital.

Section 2. Responsibilities of Chief of Staff, Vice Chief of Staff, Department and Clinical Services Chairs

2.1 Responsibilities of the Chief of Staff

2.1.1 The Chief of Staff is the primary elected officer of the Medical Staff and is the Medical Staff members 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 and Regulations and policies/procedures. 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 at all other Medical Staff committees without vote, and to participate as invited by the CEO/President or Board on Hospital or Board committees;
- c. Enforce Medical Staff Bylaws, Rules and Regulations, policies/procedures and Medical Staff/Hospital policies/procedures;
- d. Except as stated otherwise, appoint committee chairs and all members of the 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 the interdisciplinary clinical performance improvements 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, advanced practice professionals, or allied health professionals 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 members of the Medical Staff in their relations with each other, the Board, Hospital Administration, 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.

2.2 Responsibilities of the Vice Chief of Staff

2.2.1 Specific responsibilities and authority are to:

- a. Substitute in the absence of the Chief of Staff at meetings of the MEC;
- b. Serve on the MEC;
- c. Serve as Chair of the Credentials Committee;
- d. Serve as Chair of the Quality Care Committee; and
- e. Perform such further duties to assist the CEO/President and/or Chief of Staff as requested.

2.3 Responsibilities of Department Chairs

2.3.1 Specific responsibilities and authority are to:

- a. Oversee all clinically-related activities of the department;
- b. Oversee all administratively-related activities of the department, unless otherwise provided by the Hospital;
- c. Ensure cooperation with nursing services and other Hospital departments in matters affecting patient care;
- d. Monitor and evaluate the continuous assessment and improvement of the quality of care, treatment and services and appropriateness of patient care, treatment and services

- provided in his or her department and to implement action following review and recommendations by the Patient Safety Committee and/or the MEC;
- e. Provide ongoing monitoring of the professional performance of all individuals in the Medical Staff department who have been granted clinical privileges;
 - f. Monitor all individuals in his or her department to ensure individuals practice only within their delineated privileges or scope of practice;
 - g. Recommend to the Credentials Committee the criteria for requesting clinical privileges that are relevant to the care provided in his or her department;
 - h. Recommend clinical privileges for each practitioner, or advanced practice professional in his or her department;
 - i. Assess and recommend to the MEC and Hospital Administration off-site sources needed for patient care, treatment, and/or services not provided by his or her department or the Hospital;
 - j. Integrate the department into the primary functions of the hospital;
 - k. Coordinate and integrate interdepartmental and intradepartmental services and communication;
 - l. Develop and implement Medical Staff and Hospital policies/procedures that guide and support the provision of patient care, treatment and/or services;
 - m. Recommend to the Hospital Administration sufficient numbers of qualified and competent person to provide patient care, treatment and/or services;
 - n. Determination of the qualifications and competence of dependent healthcare professionals who are granted privileges or scope of practice to provide patient care, treatment and services;
 - o. Maintain quality control programs in his or her department;
 - p. Oversee the analysis and improvement of patient satisfaction;
 - q. Coordinate the orientation and continuing education in his or her department; and
 - r. Make recommendation to the MEC and the Hospital Administration for space and other resources needed by the Medical Staff department to provide patient care services.

2.4 Responsibilities of Clinical Service Chairs

2.4.1 Specific responsibilities and authority are to:

- a. Provide a mechanism by which all members of the clinical service are kept apprised of clinical service activities;
- b. Provide a forum where clinical service members can express their concerns, resolve issues and provide input;
- c. Provide for the continuous assessment and improvement of the quality of care, treatment and/or services provided;
- d. Provide for ongoing monitoring of the professional performance of all individuals in the clinical service who have delineated clinical privileges;
- e. Coordinate orientation and formulate continuing education for all practitioners in the clinical service;

- f. Assess and recommend to Hospital Administration, off-site sources for needed patient care, treatment and/or services not provided for the integration of the clinical service or the Hospital, as appropriate;
- g. Coordinate and provide for the integration of the clinical service into the primary functions of the Hospital;
- h. Develop and implement policies/procedures that guide and support the provision of clinical services with the approval of the applicable Department Chair;
- i. Recommend a sufficient number of qualified and competent persons to provide patient care, treatment and/or services, as appropriate;
- j. Make recommendations for space and other resources needed by the clinical service;
- k. Discuss equipment needs pertinent to that clinical service;
- l. Develop recommendations of a specific issue at the request of a Department Chair or the MEC;
- m. Assist in the development and recommend criteria for clinical privileges and give input on an application or reapplication, when requested by the Department Chair, Credentials Committee or MEC;
- n. Provide for the development of the qualifications and competence of allied health professionals who are granted privileges or define the scope of practice to provide patient care, treatment and/or services and are not member of the Medical Staff;
- o. Take responsibility for enforcement of the Medical Staff Bylaws, Rules and Regulations, and Medical Staff and Hospital policies/procedures within their clinical service; and
- p. Perform such other functions as may from time-to-time be assigned to him or her by the Medical Staff.

Section 3. Medical Staff Committees

3.1 Medical Executive Committee

The composition and general description of the MEC is in the Medical Staff Bylaws, Part I: Governance.

3.2 Department Committee

3.2.1 Composition: Each department may establish a Department Committee. The committee shall be comprised of all members of the department and additional members as determined by the Department Chair.

3.2.2 General Description: The committee shall meet as often as deemed necessary to accomplish departmental business and carry out departmental duties and responsibilities. The Department Chair of the respective department shall be responsible for scheduling the Department Committee meetings and will serve as the Chair. Minutes of meetings, including recommendations and actions, shall be recorded and copies forwarded to the MEC. Minutes of the Department Committee meetings shall be available for review from the Medical Staff Services Office upon request by any member of the department.

3.2.3 Responsibilities:

- a. Conduct the business of the Department;
- b. Represent and take action on behalf of the Department; and
- c. Assure the departmental functions, as outlined in Section 2.3 are accomplished by the Department.

3.3 Credentials Committee

The composition and general description of the Credentials Committee is in the Medical Staff Bylaws, Part III: Credentials Procedure Manual.

3.4 Health Information Management Committee

3.4.1 Composition: The Health Information Management Committee shall consist of appointed practitioners from the Medical Staff, the Director of Health Information Management, plus one (1) representative each from Patient Care Services, the Quality Resource Department and Hospital Administration.

3.4.2 General Description: The Health Information Management Committee shall meet at least quarterly. The Committee Chair shall be responsible for scheduling the committee meetings. Minutes of meetings, including recommendations and actions, shall be recorded and copies forwarded to the MEC. Minutes of the Health Information Management Committee meetings shall be available for review from the Health Information Management Office upon request.

3.4.3 Responsibilities:

- a. Establish medical record review criteria;
- b. Establish the annual review calendar;
- c. Analyzing the findings from the review and taking actions as appropriate;
- d. Assure that all History and Physicals are completed and on the patient record within twenty-four (24) hours of admission and prior to a procedure as explained in the Rules and Regulations;
- e. Review audits of records of discharged patients to determine the timeliness, pertinence, accuracy and completeness thereof.

3.5 Infection Control Committee

3.5.1 Composition: The Infection Control Committee shall consist of at least four (4) representatives of the Medical Staff, Infection Disease Physician and one (1) representative each from Infection Control Staff and Hospital Administration, as appropriate.

3.5.2 General Description: The Infection Control Committee shall meet at least quarterly. The Committee Chair shall be responsible for scheduling the committee meetings. Minutes of meetings, including recommendations and actions, shall be recorded and copies forwarded to the MEC for approval. The minutes of the Infection Control Committee meetings shall be maintained by the appropriate Hospital personnel.

3.5.3 Responsibilities:

- a. Surveillance of inadvertent Hospital infection potentials;
- b. Review and analysis of actual infections;
- c. Promotion of a preventative and corrective program designed to minimize infection hazards, and the supervision of infection control in all phases of the Hospital's activities to include: operating rooms, recovery rooms, special care units, sterilization procedures by heat, chemicals or otherwise;
- d. Isolation procedures;
- e. Prevention of cross-infection by anesthesia apparatus or inhalation therapy equipment;
- f. Testing of Hospital personnel for carrier status;
- g. Disposal of infectious material; and
- h. Other situations as request by the MEC.

3.6 Pharmacy-Therapeutics Committee

3.6.1 Composition: The Pharmacy-Therapeutics Committee shall consist of the Director of Pharmacy, Pharmacy Clinical Coordinator, at least four (4) representatives of the Medical Staff (preferably one (1) each from the following areas; Pediatrics; Hospitalist; Intensivists; General Surgery; Infectious Disease; and Emergency Medicine) and one (1) representative each from Hospital Administration, Nursing Department and Risk Management. Other members can be invited as deemed necessary by the committee.

3.6.2 General Description: The Pharmacy-Therapeutics Committee shall meet at least quarterly. The Committee Chair shall be responsible for scheduling the committee meetings. Minutes of meetings, including recommendations and actions, shall be recorded and copies forwarded to the MEC for approval. The minutes of the Pharmacy-Therapeutics Committee meetings shall be maintained by the appropriate Hospital personnel.

3.6.3 Responsibilities:

- a. Development and surveillance of all drug utilization policies/procedures and practices within the Hospital in order to assure optimum clinical results and minimum potential for hazard;
- b. Assist in the formulation of broad professional policies/procedures regarding the evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures and all other matters relating to drugs in the Hospital;
- c. Other situations as request by the MEC.

3.7 Continuing Medical Education and Professional Library Committee

- 3.7.1 Composition: The Continuing Medical Education and Professional Library Committee shall consist of a Chair and will include at least three (3) members of the Active Medical Staff who are highly interested in medical education. They will be appointed by the Chief of Staff.
- 3.7.2 General Description: The Continuing Medical Education and Professional Library Committee shall meet as often as deemed necessary to fulfill responsibilities. The Committee Chair shall be responsible for scheduling the committee meetings. Minutes of meetings, including recommendations and actions, shall be recorded and copies forwarded to the MEC for approval. The minutes of the Continuing Medical Education and Professional Library Committee meetings shall be maintained by the appropriate Hospital personnel.
- 3.7.3 Responsibilities:
- a. Continued organization, development and maintenance of the Medical Library;
 - b. Shall see that the Library will contain carefully selected medical textbooks, monographs of the latest editions and current medical journals in the various branches of medicine and surgery in accordance with the dictates of the Medical Staff;
 - c. Ensure that these tests and journals are cataloged and indexed for easy and ready reference;
 - d. Coordinate the educational activities of the Medical Staff to ensure a continuing medical education program that meets the needs of the Medical Staff;
 - e. Coordinate the functions necessary to aid in the preparation of suitable and attractive continuing medical education programs and to stimulate attendance by the Medical Staff and allied health professionals; and
 - f. Supervise and coordinate all educational activities and related administrative functions pertaining to programs for physicians conducted in this Hospital, in conjunction with local educational institutions, and the development of organization of educational programs directed at the community at large.

3.8 Quality Care Committee

- 3.8.1 Composition: The Quality Care Committee will be chaired by the Vice Chief of Staff and will be represented by the Chair of each Quality Subcommittee (or designee) and additional Medical Staff members as deemed appropriate. Other members shall include a representative from Hospital Administration, the Director of the Quality Resource and Risk Management Department and the Quality Assurance Administrative Assistant, as ex officio, non-voting member.
- 3.8.2 General Description: The Quality Care Committee shall meet at least quarterly. The Committee Chair shall be responsible for scheduling the committee meetings. Minutes of meetings, including recommendations and actions, shall be recorded and copies forwarded to the MEC for approval.

The minutes of the Quality Care Committee meetings shall be maintained by the Quality Department of the Hospital.

3.8.3 Responsibilities:

- a. Development of a program designed to deliver optimal patient care within available resources;
- b. Continuing review of the cause and scope of specifically identified programs or concerns, monitoring recommended actions for problem resolution and documentation of all assessment activities;
- c. Determine the process by which quality issues that are variances from the indicator system are assessed, evaluated and concluded;
- d. Determine the extent, if any, to which outside aid is used in the performance of quality assessment activities to identify and assess problems; and
- e. Report to the MEC and the Board pertinent findings that substantiate effectiveness of the overall program to enhance patient care and assure sound clinical performance.

3.9 Cancer Committee

3.9.1 Composition: The Cancer Committee shall be a standing committee to provide program leadership with duties as described in the published Standards of the Commission on Cancer. The membership of the Cancer Committee's includes the required physicians from the diagnostic treatment specialties and non-physicians from administration and supportive services for cancer care. The required coordinator or representative roles are filled by committee members/ The Breast Center reports up through the Cancer Committee to the MEC

3.9.2 General Description: The Cancer Committee shall meet at least quarterly to plan, initiate, stimulate and assess all cancer activities related to Mercy Hospital-Joplin's Cancer Program. The Committee Chair shall be responsible for scheduling the committee meetings. Minutes of meetings, including recommendations and actions, shall be recorded and copies forwarded to the MEC for approval. The minutes of the Cancer Committee meetings shall be maintained by the appropriate Hospital personnel.

3.9.3 Responsibilities:

- a. Work with Hospital Administration to develop an organization and management structure, authorized to ensure efficient and effective administration of the cancer program and services;
- b. Establish formal mechanisms to manage and evaluate standards for medical , scientific and ethical behavior; and
- c. May choose to develop an Annual Report of Cancer Program activity that meets the content requirement of the Standards of the Commission on Cancer.

3.10 Trauma Committee

- 3.10.1 Composition: The committee should be chaired by the Chief of the Trauma Service. Membership on the committee should include representation from all major services that treat trauma patients.
- 3.10.2 General Description: The Trauma Committee shall meet at least quarterly. The Committee Chair shall be responsible for scheduling the committee meetings. Minutes of meetings, including recommendations and actions, shall be recorded and copies forwarded to the MEC for approval. The minutes of the Trauma Committee meetings shall be maintained by the appropriate Hospital personnel.
- 3.10.3 Responsibilities:
- a. Critically review, evaluate and discuss the quality of care in cases of adverse outcome (complications and deaths), particularly focusing on those deaths statistically expected to survive, which were identified using outcome norms;
 - b. Make judgment about the appropriateness and quality of care in each case of adverse outcome reviewed;
 - c. Trending analysis of complications and designating focused audits;
 - d. Develop multi-disciplinary educational programs based on the needs determined from the review process; and
 - e. Assist in the credentialing and privileging of trauma service members.

3.11 Utilization Review Committee

- 3.11.1 Composition: The committee shall be comprised of physicians involved in utilization review activities and is assisted by other professional personnel. The committee does not include any individual who is directly responsible for the care of the patient whose care is being reviewed or who have a financial interest in any hospital.
- 3.11.2 General Description: The Utilization Review Committee shall meet at least quarterly. The Committee Chair shall be responsible for scheduling the committee meetings. Minutes of meetings, including recommendations and actions, shall be recorded and copies forwarded to the MEC for approval. The minutes of the Utilization Review Committee meetings shall be maintained by the appropriate Hospital personnel.
- 3.11.3 Responsibilities:
- a. Making utilization decisions as required under the Utilization Review (UR) Plan;
 - b. Analyzing utilization profiles
 - c. Evaluating the effectiveness of utilization management activities;
 - d. Identifying opportunities for improvement;
 - e. Conducting case reviews;

- f. Adopting, developing and/or modifying standardized medical care criteria, as appropriate, to assess the need for admission and continued stays (42 CFR 456.122 & 132);
- g. Developing more extensive written criteria for case types that are shown to be associated with (42 CFR 456.122 & 132):
 - i. High costs
 - ii. Frequent use of excessive services
 - iii. Patterns of care identified that require further review.
- h. Monitor compliance with internal policies/procedures, applicable standards and regulations and contractual agreements with third party payers or external review entities;
- i. Identify, select or modify written screening criteria and standards used for objective case review, with appropriate input from medical specialties;
- j. Provide adequate and timely response for those cases referred to the Medical Director;
- k. Evaluate the results and recommendations generated by the internal and external review sources and take action as appropriate;
- l. Identify those areas with suspected or documented resource management problems and initiate corrective action plans as indicated;
- m. Recommend changes in Hospital policies/procedures, Medical Staff practices or contractual agreements with external review entities, as indicated by the analysis of clinical and financial outcomes, trends and other identified concerns;
- n. Monitor improvement in utilization/resource management and clinical effectiveness following the initiation of corrective actions; and
- o. Assist in the development and implementation of education programs on identified issues for relevant professionals and support staff.

3.12 Practitioner Health Committee

3.12.1 Composition: The Practitioner Health Committee shall consist of three (3) members and shall include the Chief of Staff and two (2) other Active Medical Staff members appointed by the Chief of Staff. The Chief of Staff shall serve as the Chair of the Practitioner Health Committee.

3.12.2 General Description: The committee shall be a special committee and responsible for addressing problems dealing with impaired professional performance among practitioners. The Chief of Staff and/or Hospital CEO/President shall refer issues related to impaired practitioners to the Practitioner Health Committee. Guidelines for this committee, including its stated purpose, function, membership and the process for consultation shall be maintained in the Medical Staff Services Office and shall be redistributed to members of the Hospital Staff at two (2) year intervals.

3.12.3 Responsibilities:

- a. Establish a program for identifying and contacting practitioners who may be professionally impaired in varying degrees because of drug dependence including alcoholism or because of mental, physical or aging problems. The committee may require

- a physical examination (“fitness to work”) and/or proctoring to assist with the evaluation of mental, physical or aging problems. The committee is to offer rehabilitative help to such physicians to the extent of its ability;
- b. Establish programs for educating members of the Medical Staff to prevent substance dependence;
 - c. Notify the CEO/President when the committee believes that the impaired practitioner’s actions could endanger patients. The existence of the Practitioner Health Committee does not alter the primary responsibility of the Department Chair for clinical performance within that Department Chair’s Department; and
 - d. Report to the MEC all practitioners under consideration by the Practitioner Health Committee with appropriate follow-up and recommendation(s) for the MEC to ultimately act upon.

3.12.4 Operational Authority: The Practitioner Health Committee shall have the authority to perform the duties of the committee as outlined. Deliberations of the committee are to remain confidential, subject only to the reporting mechanism previously outlined. The Practitioner Health Committee shall report to the MEC on at least an annual basis.

Section 4. Confidentiality, Immunity, Releases, and Conflict of Interest

4.1 Confidentiality of Information

To the fullest extent permitted by law, the following shall be kept confidential:

- 4.1.1 Information submitted, collected, or prepared by a representative of this or any other healthcare facility, organization or Medical Staff for the purpose of assessing, reviewing, evaluating, monitoring, or improving the quality and efficiency of healthcare provided;
- 4.1.2 Evaluations of current clinical competence and qualifications for staff appointment/affiliation, and/or clinical privileges or specified services; and
- 4.1.3 Contributions to teaching or clinical research; or determinations that healthcare services were indicated or were performed in compliance within applicable standards of care.
- 4.1.4 This information will not be disseminated to anyone other than a representative of the Hospital or to other healthcare facilities or organizations of health professionals engaged in an official, authorized activity for which the information is needed. Such confidentiality shall also extend to information that may be provided by third parties. Each practitioner expressly acknowledges that violations of the confidentiality provided here are grounds for immediate and permanent revocation of staff appointment and/or clinical privileges or specified services.

4.2 Immunity from Liability

No representative of this healthcare organization shall be liable to a practitioner for damages or other relief for any decision, opinion, action, statement, or recommendation made within the scope of his or

her duties as an official representative of the Hospital or Medical Staff. No representative of this healthcare organization shall be liable for providing information, opinion, counsel, or services to a representative or to any healthcare facility or organization of health professionals concerning said practitioner. The immunity protections afforded in these Bylaws are in addition to those prescribed by applicable state and federal law.

4.3 Covered Activities

The confidentiality and immunity provided by this section applies to all information or disclosures performed or made in connection with this or any other healthcare facilities or organization's activities concerning, but not limited to:

- 4.3.1 Applications for appointment/affiliation, clinical privileges, or specified services;
- 4.3.2 Periodic reappraisals for renewed appointments/affiliations, clinical privileges, or specified services;
- 4.3.3 Corrective or disciplinary actions;
- 4.3.4 Hearings and appellate reviews;
- 4.3.5 Quality assessment and performance improvement/peer review activities;
- 4.3.6 Utilization review and improvement activities;
- 4.3.7 Claims reviews;
- 4.3.8 Risk management and liability prevention activities; and
- 4.3.9 Other Hospitals, committees, services, or staff activities related to monitoring and maintaining quality and efficient patient care and appropriate professional conduct.

4.4 Releases

When requested by the Chief of Staff (or designee) each practitioner shall execute general and specific releases. Failure to execute such releases shall result in an application for appointment, reappointment, and/or clinical privileges being deemed voluntarily withdrawn and not processed further.

4.5 Conflict of Interest

A member of the Medical Staff requested to perform a board designated Medical Staff responsibility (such as credentialing, peer review or corrective action) may have a conflict of interest if they may not be able

to render an unbiased opinion. An absolute conflict of interest would result if the physician is the practitioner under review, his or her spouse, or his or her first degree relative (parent, sibling, or child).

Potential conflicts of interest are either due to a practitioner's involvement in the patient's care not related to the issues under review or because of a relationship with the physician involved as a direct competitor, partner or key referral source. It is the obligation of the individual physician to disclose to the affected committee the potential conflict. It is the responsibility of the committee to determine on a case by case basis if a potential conflict is substantial enough to prevent the individual from participating. When a potential conflict is identified, the committee chair will be informed in advance and make the determination if a substantial conflict exists. When either an absolute or substantial potential conflict is determined to exist, the individual may not participate or be present during the discussions or decisions other than to provide specific information requested.

Section 5. Adoption and Approval

The Medical Staff Bylaws of Mercy Hospital Joplin have been approved and adopted as listed below:

05/01/2015 Board

“Exhibit A” Mercy Hospital Joplin Department Chairs and Clinical Services

Primary Care Department

Family Medicine Clinical Service
Internal Medicine Clinical Service
Occupational Medicine Clinical Service
Pediatrics / Neonatology / Pediatric Intensivists Clinical Service/Pediatric Subspecialties

Specialty Care Department

Cardiology Clinical Service
Dermatology Clinical Service
Endocrinology Clinical Service
Gastroenterology Clinical Service
Infectious Disease Clinical Service
Medical Specialists Clinical Service
 Allergy Clinical Service
 Rheumatology Clinical Service
Nephrology Clinical Service
Neurology Clinical Service
Oncology / Hematology Clinical Service
Physical Medicine and Rehabilitation Clinical Service
Psychiatry / Behavioral Health Clinical Service
Pulmonology Clinical Service
Radiation Oncology Clinical Service

Surgical Care Department

Anesthesiology Clinical Service
Cardiovascular and Thoracic Surgery / Vascular Clinical Service
General Surgery / Breast Surgery/Trauma Clinical Service
Neurosurgery Clinical Service
Obstetrics and Gynecology Clinical Service
Ophthalmology / Optometry Clinical Service
Orthopedics / Podiatry Clinical Service
Otolaryngology / Oral Surgery / Dentistry/ Audiology / Speech Pathology Clinical Service
Pain Management Clinical Service
Pathology Clinical Service
Plastic Surgery Clinical Service
Urology Clinical Service

Hospital-Based Specialties Department

Emergency Medicine Clinical Service
Hospitalist Clinical Service
Critical Medicine Clinical Service
Nuclear Medicine Clinical Service
Radiology Clinical Service



MERCY HOSPITAL JOPLIN

MEDICAL STAFF BYLAWS

Part V: Rules and Regulations

May 11, 2016

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Section 1. Introduction

The health care professional has the knowledge and experience to pursue the goals of healing, maintenance of health, and compassionate care of the dying, whilst taking into account the patient's convictions and spiritual needs, as well as the moral responsibilities of all concerned. The patient depends on the skills of the health care provider to assist in preservation of life and promotion of a healthy body, mind, and spirit. The patient, in turn, has a responsibility to use his or her physical and mental resources in the service of moral and spiritual goals to the best of his or her ability.

When the health care professional and the patient use institutional Catholic health care, they also accept its public commitment to the Church's understanding of and witness to the dignity of the human person. The Church's moral teaching on health care nurtures a truly interpersonal professional-patient relationship. This professional-patient relationship is never separated from the Catholic identity of the health care institution. The faith that inspires Catholic health care, guides medical decisions in ways that fully respect the dignity of the patient and their professional relationship with the health care professional.

1.1 Definitions

"Advance Directive" means a document or documentation allowing a person to give directions about future medical care, or to designate another person(s) to make medical decisions if the individual loses his or her decision making capacity. Advance directives include a "Declaration of a Desire for a Natural Death", "Do Not Resuscitate Orders" and similar documents expressing the individual's preferences as specified in the Patient Self Determination Act.

"Emergency Medical Condition" means 1) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in (a) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (b) serious impairment of bodily functions, or (c) serious dysfunction of any organ or part; 2) with respect to a pregnant woman who is having contractions (a) that there is inadequate time to effect a safe transfer to another hospital before delivery, or (b) that transfer may pose a threat to the health or safety of the woman or the unborn child.

"Family" means those persons who play a significant role in the individual's life. This may include persons who are not legally related to the individual.

"Inpatient" means a person who has been admitted to the Hospital for bed occupancy for purposes of receiving inpatient services. A person is considered an inpatient if formally admitted to a licensed inpatient bed with the expectation of remaining overnight, even if it later develops that the patient can be discharged before midnight.

"Invasive Procedure" means a procedure involving puncture or incision of the skin, or insertion of an instrument or foreign material into the body, including, but not limited to, percutaneous aspirations, biopsies, cardiac and vascular catheterizations, endoscopies, angioplasties, and implantations and excluding venipuncture and intravenous therapy.

"Life Sustaining Procedure" means a medical procedure or intervention, which serves only to prolong the dying process. Life-sustaining procedures do not include the administration of medication or other treatment for comfort care or alleviation of pain.

“Observation” means a person receives services furnished on the Hospital premises, including the use of a bed and periodic monitoring by nursing or other staff, which are reasonable and necessary to evaluate an outpatient’s condition in order to determine the need for a possible admission to the Hospital as an inpatient.

“Outpatient” means a person who has not been admitted by the Hospital as an inpatient but is registered on the Hospital records as an outpatient and receives services from the Hospital.

“Patient” means as any person undergoing diagnostic evaluation or receiving medical treatment under the auspices of the Hospital.

“Protected Health Information” means any information, whether oral or recorded in any form or medium that relates to the past, present or future physical or mental condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that identifies the individual or with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

“Stabilize” means to provide such medical treatment of an emergency medical condition which may be necessary to assure within reasonable medical probability that no medical deterioration of the condition is likely to result from or occur during the transfer of the individual from the facility.

“Surgeon” refers to any practitioner performing an operation or invasive procedure on a patient and is not limited to members of the Department of Surgery.

“Unable to Consent” or “Incompetent” means unable to comprehend the nature and implications of the patient’s condition and proposed health care, such as to be unable to make a reasoned decision concerning the proposed health care, or be able to communicate that decision in an unambiguous manner. This definition does not include minors unless they are married or have been judicially determined to be emancipated (Adult Health Care Consent Act).

Any definitions set forth in the Medical Staff Bylaws shall also apply to terms used in these Rules and Regulations.

1.2 Applicability

These Rules and Regulations are adopted by the Medical Executive Committee (MEC) and approved by the Board of Trustees (Board) to further delineate the general policies/procedures contained in the Medical Staff Bylaws and to govern the discharge of professional services within the Hospital. These Rules and Regulations are binding on all Medical Staff appointees and other individuals conferred with clinical privileges.

1.3 Conflict with Hospital Policy

These Rules and Regulations shall prevail in any case of any conflict with Hospital policies/procedures concerning the delivery of healthcare.

1.4 Amendment

These Rules and Regulations of the Medical Staff may be adopted, amended or repealed only by the mechanism provided in the Medical Staff Bylaws.

1.5 Adoption

This article supersedes and replaces any and all prior Medical Staff Rules and Regulations pertaining to the subject matter thereof.

Section 2. Admission and Discharge

2.1 Admission

2.1.1 General

The Hospital accepts short term patients for care and treatment if suitable facilities to render such care and treatment are available.

- a. Admitting Privileges: A patient may be admitted to the Hospital only by a member of the Medical Staff who has been granted admitting privileges.
- b. Admitting Diagnosis: Except in an emergency, no patient shall be admitted to the Hospital until a provisional diagnosis or valid reason for admission has been entered in the medical record. In the case of an emergency, such a notation shall be made as soon as possible.
- c. Admission Procedure: Admissions must be scheduled with the Hospital's House Supervisor (or designee). A bed will be assigned based upon the medical condition of the patient and the availability of Hospital staff and services. Except in an emergency, the admitting practitioner (or designee) shall contact the Hospital's House Supervisor (or designee) to ascertain whether a bed is available.
- d. The Medical Staff member shall be responsible at the time of admission for providing to the House Supervisor and/or other appropriate personnel such information as may be necessary to enable the Hospital to protect the patient from self-harm and to protect other patients, staff and visitors from possible sources of danger.
- e. In accordance with the regulations of the Missouri State Board of Health and the Hospital's Infection Control Policies/Procedures, It shall be the responsibility of the Medical Staff member to report all cases of reportable diseases to the Hospital.

2.1.2 Admission Priority

The Admitting Registrar will admit patients on the basis of the following order of priorities:

- a. Emergency Admission: Emergency admissions are the most seriously ill patients. The condition of this patient is one of immediate and extreme risk. These patients require immediate attention and are likely to expire without stabilization and treatment. The emergency admission patients will be admitted immediately to the first appropriate bed available.
- b. Urgent Admission: Urgent admission patients meet the criteria for inpatient admission, however, their condition is not life threatening. Urgent admission patients will be admitted as soon an appropriate bed is available. Urgent admissions include admissions for observation as determined by Center for Medicare/Medicaid Services (CMS) criteria.
- c. Elective Admission: Elective admission patients meet the medical necessity criteria for Hospitalization but there is no element of urgency for his or her health care. These

patients may be admitted on a first come, first serve basis. A waiting list will be kept and each patient will be admitted as soon as a bed becomes available.

2.1.3 Assignment to Appropriate Service Areas

Every effort will be made to assign patients to areas appropriate to their needs. Patients requiring emergency or critical care may be routed to the Emergency Department for stabilization prior to being transferred to the appropriate treatment area. Patients in active labor will be admitted directly to Obstetrical Department.

2.2 Emergency Services

The provision of emergency medical services shall be through the Emergency Department of the Hospital, organized and directed by a member of the Medical Staff, trained and experienced in Emergency Medicine and staffed by members of the Medical Staff.

A medical record shall be kept for every patient and shall become part of the Hospital's legal medical record. Past Hospital records shall be made available upon request of the Emergency Department.

A Medical Staff member determines the need to transfer a patient to another medical facility. This shall be done in accordance with the Emergency Medical Treatment and Active Labor Act (EMTALA) guidelines and the practitioner making the determination shall complete and sign all forms related to the transfer including a transfer statement.

2.2.1 Unassigned Emergency Patients

EMTALA requires that for all patients who present to the Emergency Department, the Hospital must provide for an appropriate medical screening examination within the capability of the Hospital's Emergency Department, including ancillary services routinely available to the Emergency Department so as to determine whether or not an emergency medical condition exists.

2.2.2 Definition of Unassigned Patient

Patients who present to the Emergency Department and require admission and/or treatment shall have a practitioner assigned by the Emergency Department physician if one or more of the following criteria are met:

- a. The patient does not have a primary care practitioner or does not indicate a preference;
- b. The patient's primary care practitioner does not have admitting privileges; or
- c. The patient's injuries or condition fall outside the scope of the patient's primary care practitioner.

2.2.3 Unassigned Call Service

- a. Unassigned Call Schedule: The Hospital is required to maintain a list of physicians who are on call for duty after the initial examination to provide treatment necessary to stabilize an individual with an emergency medical condition. Each individual practitioner (or

designee) shall provide the Emergency Department and Medical Staff Services with a list of physicians who are scheduled to take emergency call on a rotating basis.

- b. **Response Time:** It is the responsibility of the on-call physician to respond in an appropriate time frame. The on-call physician should respond to calls from the Emergency Department within thirty (30) minutes and must arrive at the Hospital to evaluate the patient within a time frame specified by the Emergency Department physician. If the on-call physician does not respond to being called or pages, the physician's Department Chair shall be contacted. Failure to respond in a timely manner may result in the initiation of disciplinary action.
- c. **Substitute Coverage:** It is the on-call physician's responsibility to arrange for coverage and notify the Communication Center or Medical Staff Services if he or she is unavailable to take call when assigned. Failure to notify the Communication Center or Medical Staff Services of alternate coverage may result in the initiation of disciplinary action.

2.2.4 Patients Not Requiring Admission

In cases where the Emergency Department consults with the unassigned call physician and no admission is deemed necessary, the Emergency Department physician shall implement the appropriate care/treatment and discharge the patient with arrangements made for appropriate follow-up care. It is the unassigned call physician's responsibility to provide a timely and appropriate follow-up evaluation for the patient following the Emergency Department visit.

2.2.5 Guidelines for Department Policies/Procedures on Unassigned Call

Pursuant to the Medical Staff Bylaws, clinical departments may adopt rules and regulations and policies/procedures that are binding on the members of their department. The following rules should be used in developing departmental policies/procedures regarding unassigned emergency call obligations:

- a. Unassigned call duties should be based on the appointee's clinical privileges, physicians with admitting privileges are expected to serve on the unassigned call roster regardless of their staff category.
- b. Unassigned call duties shall be apportioned equally among all eligible department members.
- c. Unassigned call duties may be divided by section, specialty, or subspecialty.
- d. An impairment which is alleged to limit an appointee's ability to provide unassigned call services shall also be grounds for limiting the appointee's privileges for providing care to their assigned or private patients.
- e. Departmental rules and regulations concerning unassigned call must be approved by the MEC.

2.3 Transfers

2.3.1 Transfer from Other Acute Care Facilities

Transfers from other acute care facilities must meet the following criteria:

- a. The patient must be medically stable for transfer;
- b. The patient's condition must meet medical necessity criteria for inpatient admission;

- c. The patient must require, and the Hospital must be able to provide, a higher level of care or a specific inpatient service not available at the transferring facility;
- d. Responsibility for the patient must be accepted by a physician with admitting privileges at the Hospital; and
- e. The transfer must be approved by a Hospital representative with authority to accept transfers.

2.3.2 Transfers Within the Hospital

Patients may be transferred from one patient care unit to another in accordance with the priority established by the Hospital. The attending practitioner will be notified of all transfers.

2.4 Patients Who Are a Danger to Themselves and Others

The admitting practitioner is responsible for providing the Hospital with necessary information to ensure the safety of the patient from self-harm as well as of anyone around the patient. Acute care admissions of suicidal patients will be accepted for those patients requiring medical stabilization. Once the patient's medical condition is stabilized, the patient will be evaluated and transferred to an appropriate outpatient or inpatient psychiatric facility.

2.5 Prompt Assessment

2.5.1 New admissions must be personally examined and evaluated by the attending physician or his or her designated covering physician within twenty-four (24) hours or sooner as warranted by the clinical circumstances. Each patient must be visited thereafter by the attending physician or an advanced practice professional on a daily basis or more frequently if the patient's condition warrants such visits. Critically ill or unstable patients (including all patients admitted to an intensive care unit) should be seen in an expeditious manner, but no later than two (2) hours following admission and visited at a minimum, daily by the attending physician.

2.5.2 Exception: Patients on the Behavioral Health Unit only require a progress note on one day of the weekend, either Saturday or Sunday, unless their condition is such to warrant a visit and note on both days. Behavioral Health physicians will be available and round on the Behavioral Health Unit on both Saturday and Sunday but are only required to see approximately half the patients per day.

2.6 Conflict of Care Resolution

All members of the health care team have a duty to advocate for the patient through the organizational chain of command when they have concerns about the patient's condition that they believe are not being addressed or they have concerns about decisions being made regarding the care being received by the patient.

The chain of command shall involve administrative and clinical lines of authority. The lines of authority are established to ensure effective conflict resolution in patient care situations. The concerned member of the team should express their concerns to their immediate supervisor. If they still feel the issue is not adequately resolved they should ask to speak to the supervisor's manager up the chain of command.

In all cases, the final authority in the chain of command on patient care decisions shall rest with the Chief of Staff (or designee).

2.7 Discharge Order and Instructions

Patients will be discharged or transferred upon the authenticated order of the attending physician (or designee) that shall provide, or assist Hospital personnel in providing, written discharge instructions in a form that can be understood by all individuals and organizations responsible for the patient's care. For patients that have been in the Hospital for a period of more than forty-eight (48) hours, the patient's discharge summary shall either be directly entered in the electronic health record or dictated within thirty (30) days of discharge. For patients with a stay of less than forty-eight (48) hours, a discharge note is not required. All inpatient deaths shall have a discharge summary regardless of length of stay. The content of the discharge summary should be consistent with the rest of the medical record and include:

- a. Admitting date and reason for Hospitalization;
- b. Discharge date;
- c. Final diagnoses;
- d. Succinct summary of significant findings, treatment provided and patient outcome;
- e. Documentation of all procedures performed during current Hospitalization and complications (if any);
- f. Condition of patient upon discharge and a notation as to where the patient was discharged;
- g. A list of all medications the patient is to take post-discharge;
- h. Dietary instructions and modifications;
- i. Medical equipment and supplies, if appropriate;
- j. Instructions for pain management, if appropriate;
- k. Any restrictions or modification of activity;
- l. Follow up appointments and continuing care instructions;
- m. Referrals to rehabilitation, physical therapy, and home health services; and
- n. Recommended lifestyle changes, such as smoking cessation.

2.8 Discharge Against Medical Advice

Should a patient leave the Hospital against the advice of the attending physician, or without a discharge order, the following actions will occur:

- a. The patient will be asked to remain in the Hospital until the attending physician can be notified;
- b. The patient will be asked to read and sign the Hospital's "Discharge Against Medical Advice" form;
- c. The patient will be assisted in leaving the facility and will be informed that they may not return directly to the patient care unit. If the patient chooses to return to the Hospital, such return will be treated as a new admission.
- d. Documentation of the attending physician's notification as well as the date, time, and mode of transfer will be made in the patient's record.

2.9 Discharge and Readmission on the Same Day

If a patient is discharged and readmitted on the same day, the admission will be considered a new admission.

2.10 Discharge Planning

Discharge planning is a formalized process through which follow-up care is planned and carried out for each patient. Discharge planning is undertaken to ensure that a patient remains in the Hospital only for as long as medically necessary. All practitioners are expected to participate in the discharge planning activities established by the Hospital and approved by the MEC.

2.11 Therapeutic Leave of Absence

Therapeutic leave of absences are limited to patients on the Rehabilitation Unit. A patient receiving acute care services may not have a leave of absence.

Section 3. Medical Records

3.1 General Requirements

The medical record provides data and information to facilitate patient care, serves as a financial and legal record, aids in clinical research, supports decision analysis, and guides professional and organization performance improvement. The medical record must contain information to justify admission or medical treatment, to support the diagnosis, to validate and document the course and results of treatment, and to facilitate continuity of care. Only authorized individuals may have access and make entries into the medical record. The attending physician is responsible for the preparation of a complete and legible medical record for each patient. Its contents will be pertinent, current, and age-specific.

To facilitate consistency and continuity of patient care, the medical record shall include:

- a. The patient's identification data and the name of any legally authorized representative;
- b. The legal status of patients receiving mental health status;
- c. Emergency care provided to the patient prior to arrival, if any;
- d. The findings of the patient's assessment, and the conclusions or impression drawn from the medical history and physical examination;
- e. The diagnosis or diagnostic impression;
- f. The reason for the admission or treatment;
- g. The goals of treatment and the treatment plan;
- h. Evidence of known advance directives;
- i. Evidence of informed consent, when required;
- j. Diagnostic and therapeutic orders, if any;
- k. All diagnostic and therapeutic procedures and tests relevant to the management of the patient's condition;
- l. All operative and other invasive procedures performed, using acceptable disease and operative terminology that includes etiology, as appropriate;
- m. Progress notes made by Medical Staff and other authorized individuals, all reassessments and any revisions of the treatment plan, clinical observations, and the patient's response to care;
- n. Consultation reports;
- o. Every medication ordered or prescribed for an inpatient, every medication dispensed to an ambulatory patient or an inpatient on discharge, and every dose of medication administered and any adverse drug reaction(s);
- p. All relevant diagnoses established during the course of care;
- q. Any referrals and communications made to external or internal care providers and to community agencies;
- r. Conclusions at termination of Hospitalization;
- s. Relevant discharge instructions to the patient and/or family; and
- t. A discharge summary or final progress note or transfer summary.

3.2 Authentication of Entries

All clinical entries in the patient's medical record will be accurately dated, timed and authenticated with the practitioner's legible signature or by approved electronic means. The electronic signature will be generated by a password which is only known to the physician.

3.3 Clarity, Legibility and Completeness

All handwritten entries in the medical record shall be made in ink and shall be clear, complete, and legible. The clarity, completeness and legibility of medical record documentation may be considered in evaluating the practitioner at the time of reappointment. Practitioners whose medical record entries are habitually unclear, incomplete or illegible may be subject to corrective actions as determined by the MEC.

3.4 Abbreviations and Symbols

The use of abbreviations can be confusing and may be a source of medical errors. However, the Medical Staff recognizes that abbreviations may be acceptable to avoid repetition of words and phrases. The use of abbreviations and symbols in the medical record must be consistent with the following rules:

Standard Abbreviations: Symbols and abbreviations may only be used when the Medical Director of Medical Records and the MEC have approved them. An official record of approved and unapproved or banned abbreviations shall be kept on file in the Hospital Health Information Management Department. Use of unapproved abbreviations has the potential to negatively impact patient care. No order for medication will be completed if the order contains a symbol or abbreviation on the unapproved list until the physician has been contacted for order clarification. Cautionary abbreviations are discouraged and should be avoided in the medical record, but if used, should be interpreted with caution and clarified if necessary. The Pharmacy & Therapeutics Committee will monitor compliance of medication orders with these requirements and report noncompliance to the MEC. For the safety of Mercy Hospital Joplin patients, Medical Staff members shall not include unacceptable abbreviations in the medical record.

Medical records should not be improperly altered. The corrected entry must be authenticated with the practitioner's signature and the date and time.

3.5 Late Entries

In situations where a late entry is necessary, this will be documented by date and time of the current entry, followed by "late entry" for the date and time the entry was to be originally documented; and then authenticated by the practitioner.

3.6 Admission History and Physical Examination

3.6.1 Time Limits

A medical history and appropriate physical examination must be entered in the medical record no more than thirty (30) days before or twenty-four (24) hours after a Hospital inpatient or observation admission.

3.6.2 Who May Perform and Document the Admission History and Physical Exam

The history and physical examination shall be performed and recorded by a doctor of medicine or osteopathy, or, for patients admitted only for oral and maxillofacial surgery, by an oral and maxillofacial surgeon. All or a part of the history and physical may be delegated to other

practitioners in accordance with state law and Hospital policy, but the MD/DO must sign the history and physical and as applicable, as well as any update note and assume full responsibility for the history and physical. This means that a nurse practitioner or a physician assistant meeting these criteria may perform the history and physical, and/or the update assessment and note.

3.6.3 Compliance with Documentation Guidelines

The documentation of the admission history and physical examination shall be consistent with the current guidelines for the documentation of evaluation and management services as promulgated by the CMS or a comparable regulatory authority. The history and physical examination report must include the following information (a consultation will be accepted as a history and physical if it has all of the requirements listed below):

- a. Chief complaint or reason for the admission or procedure;
- b. A description of the present illness;
- c. Current medications, antibiotics and nutritional supplements;
- d. Drug allergies;
- e. Past medical history, including past and present diagnoses, illnesses, operations, injuries, treatment, and health risk factors;
- f. An age appropriate social history;
- g. A pertinent family history;
- h. A review of systems;
- i. Physical findings (should include an appropriate examination of relevant body areas/organ systems):
 - Vital signs
 - Cardiovascular system
 - Respiratory system
 - Neurological system
 - Gastrointestinal system
 - Eye
 - Ear, Nose and Throat (ENT)
 - Genitourinary system
 - Musculoskeletal system
 - Skin
 - Psychiatric
 - Hematologic/lymphatic/immunologic
- j. Nutritional evaluation;
- k. 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.
- l. For surgery or invasive procedure requiring moderate sedation or anesthesia:
 - Indications
 - Proposed procedures
 - ASA classification
 - NPO status
 - Airway assessment
 - Pediatrics Only: Immunization and neonatal history (If applicable)

3.6.4 Attending Physician is Responsible for the Admission History and Physical Examination

Completion of the patient's admission history and physical examination is the responsibility of the attending physician (or designee).

3.6.5 Updated History and Physical Examination

If a history and physical examination has been performed and documented within thirty (30) days of the patient's admission to the Hospital, this history and physical examination may be used in the patient's Hospital medical record provided that an "Updated History and Physical Examination" is entered in the medical record no more than twenty-four (24) hours after admission or prior to surgery. The updated history and physical examination must:

- a. Address the patient's current status and/or any changes in the patient's status (if there are no changes in the patient's status, this should be specifically noted);
- b. Include an appropriate physical examination of the patient to update any components of the exam that may have changed since the prior history and physical, or to address any areas where more current data is needed;
- c. Confirm that the necessity for the admission, procedure, or care is still present;
- d. Be written or otherwise recorded on, or attached to, the previous history and physical; and
- e. Be placed in the patient's medical record within twenty-four (24) hours after admission or prior to surgery or performance of an invasive procedure for which a history and physical is required per Section 3.7.1.

3.6.6 History and Physical Requirements for Patients Transferred to Another Level of Care

Patients who are being discharged and transferred to another level of care (e.g. rehabilitation patients being admitted back to acute care), the discharge summary or a progress note will suffice as documentation of the history and physical examination.

3.7 Preoperative Documentation

3.7.1 Policy

Except in an emergency, a current medical history and appropriate physical examination will be documented in the medical record prior to:

- a. All invasive procedures performed in the Hospital;
- b. Invasive procedures performed in the Radiology Department and Cath Lab (e.g. angiography, angioplasty, myelograms, abdominal and intrathoracic biopsy or aspiration, pacemaker and defibrillator, implantation);
- c. Electrophysiologic studies and ablations;
- d. Invasive procedures performed in other treatment areas (e.g. bronchoscopy, gastrointestinal endoscopy);
- e. Transesophageal echocardiography, therapeutic nerve blocks, central line insertions, and elective electrical cardioversion.

3.7.2 Procedure

- a. Inpatient/Observation Patient Who Requires Surgery: This patient should already have an admission history and physical in their chart. The surgeon should enter a pre-procedure progress note or consultation note documenting the provisional diagnosis, the indications for the procedure, and any changes in the patient's condition since the admission history and physical. If there are no changes in the patient's condition, this should be specially noted.
- b. New Inpatient/Observation Patient Surgical Admission: The attending physician must record an admission history and physical examination as described in Section 3.6. If the admission history and physical examination is performed by a physician other than the surgeon (e.g., the patient's attending physician or a consulting physician) the surgeon should enter a pre-procedure progress note or consultation note documenting the provisional diagnosis, the indications for the procedure, and any changes in the patient's condition since the admission history and physical examination. If there are no changes in the patient's condition, this should be specially noted.
- c. Outpatient Surgery: The surgeon should complete a history and physical examination that may include an abbreviated physical examination focused appropriately to correspond to the planned procedure. The MEC may adopt a form to document the focused pre-operative history and physical examination.
- d. Outpatient Surgery Patient Subsequently Admitted to Observation/Inpatient: The surgeon should have already completed a focused pre-operative history and physical examination. Upon admission, an "Admission History and Physical Examination" as described in Section 3.6 must be documented within twenty-four (24) hours by the attending physician (or designee), specifically addressing any changes in the patient's condition since the completion of the focused pre-operative history and physical examination.

3.8 Progress Notes

The attending physician or his or her covering physician will record a progress note each day and at the time of each patient encounter on all hospitalized patients that is sufficient to ensure continuity of care and transferability. Each of the patient's clinical problems shall be clearly identified in the progress notes and correlated with specific orders as well as results of tests and treatment.

3.9 Operative Care of Patients

3.9.1 Brief Operative Note

A brief operative note shall be documented in the progress notes immediately following surgery if the operative note has not been placed directly in the medical record (inpatient or outpatient) before the patient can be transferred to the next level of care. If the practitioner performing the operation or procedure accompanies the patient from the operating room to the next area of care, the note can be written in the next area of care. Brief operative notes will include:

- a. Name of the primary surgeon who performed the procedure and his or her assistant(s);
- b. Name of the procedure(s) performed;
- c. Description of the procedure;
- d. Estimated blood loss;
- e. Any specimen(s) removed; and
- f. Postoperative diagnosis.

3.9.2 Operative Report

An operative note must be dictated for transcription or placed directly in the medical record within twenty-four (24) hours after surgery. The report should contain:

- a. Name(s) of the primary surgeon who performed the procedure and his or her assistant(s);
- b. Name of surgical procedure(s) performed;
- c. Description of the procedure(s) performed;
- d. Findings of the procedure(s);
- e. Any estimated blood loss;
- f. Any specimen(s) removed; and
- g. Postoperative diagnosis;

3.10 Post Anesthesia

A post anesthesia follow-up report by an anesthesiologist (or designee) must be documented within forty-eight (48) hours after surgery and must be:

- a. Recorded in the patient's electronic or paper anesthesia record; and
- b. Specifically document any intra-operative or postoperative anesthesia complications.

3.11 Consultation Reports

The documentation in the consultation report shall be consistent with the current guidelines for the documentation of evaluation and management services as promulgated by CMS or comparable regulatory authority. Consultation reports will demonstrate evidence of review of the patient's medical record by the consultant, pertinent findings on examination of the patient, the consultant's opinion and recommendations. This report will be made part of the patient's record. The consultation report should be completed and placed on the patient's chart within the time frame specified by the physician ordering the consult and no later than twenty-four (24) hours.

If the report is not on the chart within the prescribed time, an explanatory note should be recorded in the chart. When operative procedures are involved, the consultation note, except in emergency situations so verified on the record, will be recorded prior to the operation.

3.12 Obstetrical Record

The obstetrical record must include an admission history and physical examination as described in Section 3.6 above including a complete prenatal record.

3.13 Final Diagnoses

The final diagnoses will be recorded in full, without the use of symbols or abbreviations, dated and signed by the attending physician on discharge, transfer or death of the patient. The final diagnoses shall include the following components:

- a. **Principal Diagnosis:** The condition established after study to be chiefly responsible for occasioning the admission to the Hospital for care. The principal diagnosis should be as specific as possible. A sign or symptom should not be used as the principal diagnosis if a more specific diagnosis is known or suspected.
- b. **Other Diagnoses:** All conditions that exist at the time of admission or that developed subsequently and affected the treatment received and/or the length of stay. Diagnoses that

related to an earlier episode and that have no bearing on the current Hospital stay are not to be reported.

- c. Principal Procedure: A procedure performed for definitive treatment rather than diagnostic or exploratory purposes or that was necessary to treat a complication. The principal procedure is usually related to the principal diagnosis.
- d. Other Procedures.
- e. Comorbid Conditions: Pre-existing conditions that because of its presence with a specific diagnosis causes an increase in length of stay.
- f. Discharge Status: The disposition of the patient at discharge (for example: left against medical advice, discharged home, transferred to an acute care Hospital, expired).

3.14 Discharge Summaries

The content of the medical record will be sufficient to justify the diagnosis, treatment, and outcome. All discharge summaries will be authenticated by the attending physician (or designee).

3.14.1 Content: A clinical summary will be written or dictated upon the discharge or transfer of Hospitalized patients. The discharge summary is the responsibility of the attending physician and will contain:

- a. Reason for hospitalization;
- b. Procedures performed;
- c. Summary of the care, treatment and services provided;
- d. Complications: A condition that arises during the Hospital stay that prolongs the length of stay;
- e. Pertinent Test Results;
- f. Signs, symptoms and pertinent physical findings;
- g. Any Suspected Conditions and What Was Done to Investigate or Evaluate Them;
- h. Information provided to the patient and family;
- i. Final diagnosis; and
- j. Provisions for follow-up care.

3.14.2 Short Term Stays: A discharge summary is not required for uncomplicated inpatient and observation Hospital stays of less than forty-eight (48) hours, uncomplicated vaginal deliveries, and normal newborn infants, provided the discharging physician enters a final progress note or completes a discharge form documenting the following:

- a. The condition of the patient at discharge; and
- b. Instructions given to the patient and family, including medications, referrals and follow up appointments.

3.14.3 Deaths: The physician pronouncing death shall be responsible for determining if the death is reportable to the Medical Examiner's Office and shall make such reports in accordance with the applicable Missouri laws. A clinical summary is required on all inpatients who have expired and will include:

- a. Reason for admission;
- b. Summary of Hospital course; and
- c. Final diagnoses.

- 3.14.4 Timing: A discharge summary must be entered in the medical record within four days (4) of discharge, transfer or death of the patient.
- 3.14.5 A copy of the discharge summary should be sent to any known medical practitioner and/or medical facility responsible for the subsequent medical care of the patient as identified by the discharging physician.

3.15 Diagnostic Reports

Diagnostic reports (including but not limited to EEGs, EKGs, echocardiograms, stress tests, Doppler studies) must be read, within a reasonable time frame, by the physician scheduled to provide the interpretation service.

3.15 -Quality Improvement Organization or Primaris

All Medical Staff members are required to respond to any **Quality Improvement Organization – Primaris** pending denial within the time frame required by the **QIO – Primaris** as a basic responsibility of staff privileges. The appropriate department will review all charts finally denied by the **QIO- Primaris**.

3.17 Advanced Practitioner Professionals and Allied Health Professionals

The supervising physician will review and authenticate all entries made in the medical record by members of the Advanced Practitioner Professionals and Allied Health Professional Staff within twenty-four (24) hours. The signature signifies that the supervising physician has reviewed the patient's medical record and approved the entries rendered by the Advanced Practitioner Professional or Allied Health Professional.

3.18 Confidentiality and Access

3.18.1 Confidentiality

All members of the Medical Staff, Advanced Practitioner Professionals and Allied Health Professionals shall maintain the confidentiality, privacy and security of all Protected Health Information (PHI) in records maintained by the Hospital or by business associates of the Hospital, in accordance with any and all privacy and security policies/procedures adopted by the Hospital to comply with current federal, State and local laws and regulations, including but not limited to the Health Insurance Portability & Accountability Act (HIPAA) privacy regulations. PHI shall not be requested, accessed, used, shared, removed, released or disclosed except in accordance with the Hospital's Health Information Privacy Policies/Procedures and applicable law. The Medical Staff member can furnish medical record information about a patient whom a Medical Staff member is treating to any health care provider within the facility who has responsibility for that patient's care.

Passwords used by a member of the Medical Staff to access the Hospital's computers shall be used only by such member and shall not be disclosed to any other individual. The use of a member's password is equivalent to the electronic signature of the member. The member shall not permit any other person to use his or her password to access the Hospital's computers or computerized medical information. Any misuse may, in addition to any sanctions approved by the Hospital's Board regarding security measures, be a violation of State and federal law and may result in denial of payment under Medicare and Medicaid.

3.18.2 Access

All electronic data pertaining to the medical care of individual patients is a part of the legal medical record and is the property of the Hospital. If requested, the record will be made available to any member of the Medical Staff attending the patient and to members of Medical Staff of other Hospitals. Upon proper executive authorization, signed by the patient or the patient's legal representative, the Hospital will disclose and/or furnish copies of the patient's medical record to the requesting Hospital, insurance company, attorney and/or patient according to the policies/procedures of the Hospital. Medical records will otherwise be disclosed only pursuant to court order, subpoena, or statute. Records will not be removed from the Hospital's jurisdiction or safekeeping except in compliance with a court order, subpoena, or statute.

- a. Access to Old Records: In case of readmission of a patient, all previous records will be made available to the admitting practitioner whether the patient was attended to by the same practitioner or by another practitioner.
- b. Unauthorized Removal of Records: Unauthorized removal of charts from their designated space(s) is grounds for suspension of privileges of the practitioner for a period to be determined by the MEC.
- c. Access to Medical Research: Access to medical records of all patients will be afforded to members of the Medical Staff for bona fide study and research whilst being consistent with preserving the confidentiality of personal information concerning the individual patient. All such projects must have prior approval of the Institutional Review Board. The written request will include (1) The type of study; (2) the goals and objectives of the study; and (3) the method of record selection. All approved written requests will be presented to the Director of the Health Information Management Department.

3.19 Health Insurance Portability and Accountability Act

The Health Insurance Portability and Accountability Act, Standards for Privacy of Individually Identifiable Health Information ("HIPAA Privacy Rule") allows for an Organized Health Care Agreement (OHCA). The primary advantage of participation in an OHCA is that legally separated covered entities may disclose Protected Health Information (PHI) to other covered entities that participate in the arrangement. PHI applies to any individually identifiable health information collected or stored by a facility. Individually identifiable health information includes demographic information and any information that relates to past, present or future physical or mental condition of an individual. Such exchanges of information can help both entities provide patient care in a more effective and efficient manner. This arrangement between the Hospital and all individuals holding medical staff appointment and/or clinical privileges at the Hospital allows the sharing of PHI, for payment and operations purposes without requiring the patient to sign separate authorization forms.

The Hospital shall assume the OHCA is in place unless the practitioner, advanced practice professional (APP) or Allied Health Professional (AHP) with clinical privileges specifies the decision to opt-out of the OHCA at the time of applying for appointment and/or privileges. If the practitioner, APP or AHP opts out of the OHCA, an opt-out form must be requested and completed. The opt-out form requires that the practitioner, APP or AHP agree to:

- a. Provide a signed and dated patient authorization, which meets all of the HIPAA Privacy Rule requirements, if practitioner, APP or AHP is to receive PHI from a designated record set for purposes of billing or office operations within his or her practice;
- b. Provide each patient at the Hospital in which applicant has contact or treats, a Notice of Privacy Practices, as required under the Rule;
- c. Read, understand and abide by the Hospital's HIPAA policies/procedures set forth for patient rights, e.g. right to amend, right to request restriction, right to access;
- d. Provide each patient at the Hospital in which practitioner, APP or AHP has contact, a Privacy Consent, as required under the HIPAA Rule; and
- e. Agrees to route all requests, inquiries or complaints related to the HIPAA Privacy Rule to Medical Staff Services.

3.20 Medical Record Completion

3.20.1 Medical records must be completed in accordance with the following standards:

- a. An Admission History and Physical Examination or Updated History and Physical Examination must be entered in the medical record by the attending physician or his or her covering physician within twenty-four (24) hour of admission;
- b. Except in an emergency, a Preoperative History and Physical Examination or Focused Preoperative History and Physical Examination must be entered in the medical record prior to the surgery or procedure;
- c. An Admission Prenatal Record must be entered in the medical record by the attending physician or designated covering physician within twenty-four (24) hours of an obstetrical admission;
- d. A brief Operative Report must be entered in the medical record by the performing practitioner immediately following the surgery or procedure. The complete operative report must be dictated for transcription or placed directly in the medical record within Twenty-four (24) hours;
- e. An Inpatient Progress Note must be recorded and authenticated by the attending physician or designated covering physician at the time of each encounter and on a daily basis;
- f. An Emergency Department Record must be completed by the responsible practitioner within twenty-four (24) hours of the encounter;
- g. A Consultation Note must be completed by the consulting physician within twenty-four (24) hours of the consult request;
- h. A Discharge Summary must be entered in the medical record by the attending physician (or designee) within four (4) days of an inpatient or observation discharge, transfer or death; and
- i. The Inpatient or Observation Medical Record must be completed within thirty (30) days of discharge, including the authentication of all progress notes, consultation notes, operative reports, verbal and written reports, final diagnoses, and discharge summary.

3.21 Electronic Records and Signatures

“Electronic signature” means any identifier or authentication technique attached to, or logically associated with, an electronic record that is intended by the party using it to have the same force and effect as a manual signature. Pursuant to state and federal law, electronic documents and signatures shall have the same effect, validity, and enforceability as manually generated records and signatures.

Section 4. Communication and General Conduct of Care

4.1 Communication

Patients (or their surrogates) should receive timely information and have regular opportunities for discussion with the attending physician.

Appropriate members of the health care team should receive timely information and communication from the physician in order to assure continuity of care.

The attending physician and the consulting physician(s) should arrive at the patient's treatment plan by discussing patient care issues directly among themselves and not by means of messages through other members of the health care team.

4.2 General Conduct of Care

4.2.1 Continuity of Care

Each member of the Medical Staff who will be unavailable for patient care will make arrangements with another practitioner to cover his or her patients and will make this information available to the Hospital. Alternate Medical Staff members must be in good standing and have equivalent clinical privileges at the Hospital. In case of failure to fulfill the above, the CEO/President of the Hospital, the Chief of Staff or the Chair of the department concerned, shall have the authority to call any member of the Active Staff to provide care for the patient.

4.2.2 Time Out and Site Marking for Surgical/Invasive Procedures

A preoperative verification, marking of the surgical/procedure site (when required), and time out will be performed before every surgery/procedure performed in all operating rooms or non-surgical units. Please refer to Mercy Hospital Joplin administrative policy/procedure #OP-248 "Time Out and Site Marking for Surgical/Invasive Procedures."

4.2.3 Disclosure of Unanticipated Outcomes

In the event of an unanticipated outcome, the practitioner shall notify the CEO/President, Chief Operating Officer, or the Administrator on Call. The Administrator (or designee) will determine if the unanticipated outcome meets the Hospital's defined level of significance for the anticipated outcome and will determine who (i.e.; Ethics, Mission, Chaplain, Social Services, Risk Management, Legal Council), in addition to the responsible physician, will make the disclosure to the patient/representative.

4.2.4 Red Rule

The MEC may authorize the use of "red rule" designation to a written clinical care process. Such designation serves to clarify for medical and nursing staff that the clinical care process is enforceable as a "red rule." The designation of a "red rule" will constitute a requirement that the clinical care process actions or requirements must be followed by the Medical Staff as outlined in specific written care process. The "red rule" designation also identifies a clinical care process that should be stopped by a co-worker or nurse if the physician has not complied with all the required care process steps. Exceptions are granted for emergent condition or as deemed necessary by the

MEC. Any single instance of non-compliance by Medical Staff is subject to peer review and disciplinary action as deemed necessary by the MEC. Only the MEC has the authority to designate a clinical care process as enforceable as a "red rule" for the Medical Staff. Any clinical care process so designated will be thoroughly distributed to the Medical Staff such that it will be common knowledge.

Section 5. Standards of Practice

5.1 Attending Physician

5.1.1 Responsibilities

Each patient admitted to the Hospital shall have an attending physician who is an appointee of the Medical Staff with admitting privileges. The admitting physician shall assume attending responsibilities, transfer attending responsibility to another medical staff member with appropriate clinical privileges or an APP working under a collaborative agreement with a medical staff member having appropriate clinical privileges.

The attending physicians will be responsible for:

- a. The medical care and treatment of each patient on which he/she is either the attending or record to the Hospital under his or her name;
- b. Making daily rounds; directly or via an APP working under a collaborative agreement;
- c. The prompt, complete and accurate preparation of the medical record;
- d. Issuing any necessary special instructions regarding the care of the patient; and
- e. Transmitting reports of the condition of the patient.

5.1.2 Identification of Attending Physician

At all times during a patient's hospitalization, the identity of the attending physician will be clearly documented in the medical record.

5.1.3 Transferring Attending Responsibilities

Whenever the responsibilities of the attending physician are transferred to another Medical Staff member, a note covering the transfer of responsibility will be entered on the medical record by the transferring and accepting physicians.

5.2 Coverage and Call Schedules

All physicians will provide Medical Staff Services with a list of designated Medical Staff members (usually the members of his or her group practice who are members of the same clinical department and have equivalent clinical and procedure privileges) who will be responsible for the care of their patients in the Hospital when the physician is not available. Each physician is responsible for providing Medical Staff Services with a current and correct on-call schedule.

5.3 Responding to Calls and Pages

Practitioners are expected to respond promptly to calls from the Hospital's patient care staff regarding their patients.

5.4 Orders

5.4.1 General Principals

- a. All orders for treatment shall be in writing or entered into computerized physician order entry (CPOE) system, dated and timed, and signed by the issuing practitioner.
- b. Orders must be clear and unambiguous.
- c. All orders must be specifically given by a practitioner who has been granted such privileges.
- d. Vague or “blanket” orders (such as “continue home medication” or “resume previous orders”) will not be accepted.
- e. Instructions should be written in plain English. Prohibited abbreviations may not be used.
- f. In the outpatient setting, practitioner orders for diagnostic testing and imaging shall be acceptable for a period of one (1) year (not to exceed 365 days) from the date the order is written.

5.4.2 Verbal/Telephone Orders

Verbal/telephone orders are discouraged and should be reserved for those situations when it is impossible or impractical for the practitioner to write the order or enter as a COPE.

Verbal/telephone orders must comply with the following criteria:

- a. The order must be given to an individual who is authorized by Hospital to receive verbal orders in accordance with current laws and regulations.
- b. Verbal orders should be stated slowly, clearly, and articulately to avoid confusion. Verbal orders, like written orders, should be conveyed in English.
- c. Documentation of the verbal order includes the date and the names of the individuals, who gave, received and recorded, and implemented the orders.
- d. The authorized person receiving the order must read the order back to the prescribing practitioner.
- e. All verbal orders must be signed by the ordering practitioner or another practitioner involved in the patient’s care within forty-eight (48) hours.
- f. The following orders may not be given verbally:
 - Orders for cancer chemotherapy;
 - A “Do Not Resuscitate” order, except under the circumstances described in Subsection 8.1.5 (“Verbal and Telephone Do Not Resuscitate (DNR) Orders”).
 - An order to withhold or withdraw life support (See Section 7.1).

5.4.3 Facsimile Orders

Orders transmitted by facsimile shall be considered properly authenticated and executable provided that:

- a. The facsimile is legible and received as it was originally transmitted by facsimile or computer;
- b. The order is legible, clear and complete;
- c. The identity of the patient is clearly documented;
- d. The facsimile contains the name of the ordering practitioner, his address, and a telephone number for verbal confirmation, the time and date of transmission, and the name of the

- intended recipient of the order, as well as any other information required by federal or state law;
- e. The original order, as transmitted, is signed, dated and timed; and
 - f. The facsimile, as received, is signed by the attending physician or ordering practitioner within thirty (30) days of discharge.

5.4.4 Electronic Orders

The MEC will develop and maintain policies/procedures regarding the use of electronic orders and computerized order entries consistent with prevailing federal and state law. Orders which are sent via text shall not be utilized and are not recognized as an appropriate order.

5.4.5 Illegible, Unclear or Incomplete Orders

A practitioner's handwritten orders will be written with ink on forms approved by the MEC, and will be clear, legible, and complete. Orders which are, in the opinion of the authorized individual responsible for executing the order, illegible, unclear, incomplete, or improperly written (such as those containing prohibited abbreviations and symbols) will not be implemented. Improper orders shall be called to the attention of the ordering practitioner immediately. The authorized individual will contact the practitioner, request a verbal order for clarification, read back the order, and write the clarification in the medical record. The ordering practitioner must sign this verbal order, as described in Subsection 5.4.2. Practitioners with poor handwriting may be required to print or type medication orders.

5.4.6 Error Correction

Improperly corrected orders can lead to medical errors. If an error is made in writing an order, the entire order should be rewritten. A single line should be drawn through the erroneous order followed by the words "cancel" or "error" and the practitioner's initials. If an error is made in an electronic order, the incorrect order should be discontinued (with reason for cancellation to be "error") and the practitioner should re-enter the correct order.

5.4.7 Cancellation of Orders Following Surgery or Transfer

All previous orders are cancelled when the patient:

- a. Goes to surgery;
- b. Is transferred to a critical care area;
- c. Is transferred to a general medical unit from a critical care area;
- d. Is transferred from the Rehabilitation unit to an acute care area; or
- e. Is transferred to, and readmitted from, another Hospital or health care facility.

New orders shall be specifically written following surgery or the aforementioned transfers. Instruction to "resume previous orders" will not be accepted.

5.4.8 Paper/Electronic Order Forms

- a. Required-Use Order Forms: The MEC may adopt and require the use of specific order forms. Prior to adoption, these order forms need to be reviewed by Pharmacy & Therapeutics Committee.

- b. Periodic Review: Order forms shall be periodically reviewed.

5.4.9 Range and Conditional Orders

The ordering practitioner is responsible for evaluating the patient's status and reviewing all existing therapies before ordering, modifying, or discontinuing a particular therapy. The practitioner should evaluate the patient's response to therapy by monitoring clinical signs, symptoms, and relevant laboratory data, and by periodically reevaluating the need for continuing therapy. This responsibility should not be delegated by the use of "range" or "conditional" orders (i.e., orders that instruct nurses to start, stop, modify, or adjust treatment based on certain parameters which depend on the evaluation and judgment of nurses or other patient care professionals).

5.4.10 Drugs and Medications

- a. Hospital Formulary: So as to assure the availability of quality pharmaceuticals at a reasonable cost, practitioners shall comply with the formulary system established by the MEC upon the recommendation of the Pharmacy Director and/or Pharmacy and Therapeutics Committee. Any practitioner may submit a request for addition of a drug to the Hospital formulary prior to its need. These requests shall be submitted to the Pharmacy Director. Drugs will be added to, or removed from, the formulary based on evidenced-based criteria.
- b. Substitution: Medication orders written for trade-name drugs may be dispensed as the formulary generic drug unless the physician specifically writes "Do Not Substitute" on the patient order sheet. The MEC shall adopt policies/procedures concerning automatic therapeutic substitution upon the recommendation of the Pharmacy Director and/or Pharmacy and Therapeutics Committee.
- c. Approved Drugs: Only drugs and medications listed in the latest edition of United States Pharmacopoeia, National Formulary, American Hospital Formulary Service, or AMA Drug Evaluations may be administered to patients in the Hospital, the only exception being drugs for bona fide clinical investigations.
- d. Investigational Drugs: Investigational drugs shall be used in full compliance with the guidelines established by the Hospital's Institutional Review Board and shall comply with all regulations of the US Food and Drug Administration and Drug Enforcement Administration.
- e. Controlled Substance: Only practitioners holding a currently valid DEA (Drug Enforcement Agency) Controlled Substances Registration Certificate may write orders for narcotics or drugs classified in the DEA Controlled Substances Category.
- f. Definition of a Complete Order: All medication orders shall include the drug name, the metric mass or concentration, the dosage form, the route of administration, the schedule of administration, and if appropriate, the date and time of discontinuation. If appropriate, a dilution and rate of administration should be specified. All medication orders that are incomplete will be called to the attention of the ordering practitioner for clarification prior to being dispensed.
- g. Nomenclature: When ordering medications, standard nomenclature must be employed, using the United States Adopted Names i.e. approved generic name, the official name, or the trademarked name (if a specific product is required). Prohibited abbreviated names and symbols should not be used.
- h. Dosing Formats: SI Metric System units must be used in medication orders except for therapies that use standard units (such as insulin and vitamins). Exact dosage strengths

(such as milligrams) shall be used rather than dosage form units (such as “vials” or “ampules”). Apothecary and avoirdupois system units (i.e., grains, drams, minims, and ounces) shall **not** be used. A leading “0” must precede a decimal expression of less than one (e.g., 0.5mL). A terminal “0” (e.g., 5.0 mL) following an integer should **not** be used. The use of decimals should be avoided when possible (e.g., prescribe 500 mg instead of 0.5 g).

- i. PRN Orders: “PRN” or “as needed” orders must be qualified by listing the indication for the medication.
- j. Drug administration errors, adverse drug reactions, and incompatibilities shall be immediately reported to the attending physician and are also reported through the Mercy Event Reporting System (MERS).
- k. Automatic Stop Orders: Drugs and medications not specifically prescribed as to time or number of doses must automatically be stopped after a reasonable time that is established by the MEC upon the recommendation of the Pharmacy Director or Pharmacy and Therapeutics Committee.

5.4.11 “Stat” Orders

“Stat” or “now” orders should only be used when the practitioner expects Hospital personnel to place all other tasks on hold so that they may execute the order as soon as possible. “Stat” and “now” orders should be reserved for true emergency situations and should not be used for the convenience of the practitioner. Inappropriate use of “stat” and “now” orders may be grounds for corrective action.

5.5 Consultation

5.5.1 Any qualified practitioner with clinical privileges may be requested for consultation within his or her area of expertise. The attending physician is responsible for obtaining consultation whenever patients in his or her care require services that fall outside his or her scope of delineated clinical privileges. The attending physician will provide written authorization requesting the consultation, and permitting the consulting practitioner to attend or examine his or her patient. This request shall specify:

- a. The reason for the consultation;
- b. The urgency of the consultation; and
- c. Whether the attending physician requests the consulting practitioner to only render an opinion, to provide treatment in his or her area of specialty, or assume the role of attending physician.

5.5.2 If a nurse has any reason to question the care provided to any patient, or believes that appropriate consultation is needed, the nurse will bring this concern to attending physician and/or a group associate. If unresolved, the nurse should contact the practitioner’s Department Chair. All practitioners should be receptive to obtaining consultation when requested by patients, their families and Hospital personnel.

5.6 Death in Hospital

5.6.1 Pronouncing and Certifying the Cause of Death

In the event of a Hospital death, the deceased will be pronounced by the attending practitioner (or designee) within a reasonable time. The attending physician will be responsible for certifying the cause of death and completing the death certificate in a timely manner.

5.6.2 Organ Procurement

When death is imminent, physicians should assist the Hospital in making a referral to its designated organ procurement organization before a potential donor is removed from a ventilator and while the potential organs are still viable.

5.7 Autopsy

It shall be the duty of all staff members to secure meaningful autopsies whenever possible. If an autopsy is indicated, the deceased patient's next of kin shall be asked by the attending physician if they desire or will give permission for an autopsy to be performed. An autopsy may be performed only with a written consent, signed in accordance with state law. All autopsies shall be performed by the Hospital Pathologist or by a practitioner delegated this responsibility. Provisional anatomic diagnoses will be on the chart within three (3) days and the complete protocol should be made a part of the record within sixty (60) days. Autopsy is not required or desirable in every hospital death. However, in certain classes of hospital deaths, an autopsy can be a helpful medical procedure. Medical staff members are encouraged to request appropriate autopsy data in the following situations:

- a. Cases where the autopsy may explain unanticipated complications or changes in the clinical course;
- b. Cases where the major diagnosis is not defined or discoverable before death;
- c. Cases of unexplained and/or unexpected deaths occurring during or following a medical or surgical diagnostic procedure.
- d. Cases where significant unanswered clinical questions exist;
- e. Cases deaths from contagious disease unless the etiologic agent is known with certainty and it is thought that the performance of the procedure will not impose excessive risk on uninvolved personnel; or,

The coroner must be notified of any deaths of an individual less than eighteen (18) years of age. The coroner must also be notified in the case of any deaths involving suspected abuse or homicide or any death in which the individual died without medical attendance. Cases involving disease such as Creutzfeldt-Jakob disease will not be autopsied locally in as much there are no local facilities to prevent transmission of these diseases. Assistance will be given in referral to a regional research center where an autopsy may be performed. Autopsies will be audited and reviewed by the Quality Resources Department annually and/or as need arises.

5.8 Supervision of Advanced Practice Professionals

5.8.1 Definition of Advance Practice Professionals

Advanced Practice Professionals (APPs), including Clinical Psychologists, Advanced Practice Nurses, and Physician Assistants are licensed or certified health care practitioners whose license or certification does not permit and/or the Hospital does not authorize the independent exercise of clinical privileges. APPs may provide patient care only under the supervision of a physician who is a member of the Medical Staff and are not eligible for Medical Staff membership.

5.8.2 Guidelines for Supervising Advanced Practice Professionals (APP)

- a. The physician is responsible for managing the health care of patients in all settings.
- b. Health care services delivered by physicians and by APPs under this supervision must be within the scope of each practitioner's authorized practice as defined by state law.
- c. The physician is ultimately responsible for coordinating and managing the care of patients and with the appropriate input of the APP ensuring the quality of health care provided to patients.
- d. The physician is responsible for the supervision of the APP in all settings.
- e. The role of the APP in the delivery of care shall be defined through mutually agreed upon Supervision Agreement that is developed by the physician and the APP, excluding Clinical Psychologist.
- f. The physician must be available for consultation with the APP at all times, either in person or through telecommunication systems or other means.
- g. The extent of the involvement by the APP in the assessment and implementation of treatment will depend on the complexity and acuity of the patient's condition and the training, experience and preparation of the APP, as adjudged by the physician.
- h. Patients should be made clearly aware at all times whether they are being cared for by a physician or an APP.
- i. The physician and APP, excluding Clinical Psychologists, together should review all delegated patient services on a regular basis, as well as the mutually agreed upon Supervision Agreement
- j. The supervising physician is responsible for clarifying and familiarizing the APP with his or her supervising methods and style of delegating patient care.
- k. Each APP must document the identity of their supervising physician and one or more alternate supervising physician.

5.8.3 Supervision Agreement

Each APN and PA must have on file in Medical Staff Services a written Supervision Agreement that describes all health care-related tasks which may be performed by the APP. This document must be signed by the APP, the supervising physician, and all alternate supervising physicians. The Supervision Agreement shall be submitted to the Credentials Committee and the MEC for approval before the APP can provide services to patients at the Hospital. The Supervision Agreement must include:

- a. The name, license number and address of all supervising physicians;
- b. The name and practice address of the dependent practitioner;
- c. The date the guidelines were developed and dates they were reviewed and/or amended;
- d. Medical conditions for which therapies may be initiated, continued or modified;
- e. Treatments that may be initiated, continued or modified;
- f. Drug therapies, if any, that may be prescribed with drug-specific classifications; and
- g. Situations that require direct evaluation by or immediate referral to the supervising physician.

5.8.4 Supervising Physician

The supervising physician must not be more than thirty (30) minutes travel time from the Hospital. A physician may not supervise more than three (3) APPs. An APP may make rounds and

record progress notes. The supervising physician shall personally see and examine each inpatient, with appropriate chart documentation, at admission and on discharge and when there is a significant change in the patient's condition,
A Medical Staff member who fails to fulfill responsibilities defined in this section and/or in a Supervision Agreement for the supervision of an APP or other dependent health care professional shall be subject to appropriate corrective action as provided in Part II (Investigations, Corrective Actions, Hearing and Appeal Plan) of the Medical Staff Bylaws.

5.8.5 Other Limitations on Advanced Practice Professionals

An APP may not:

- a. Provide a service which is not listed and approved in the Supervision Agreement on file in Medical Staff Services;
- b. Perform or provide a service which he/she has not been granted clinical privileges;
- c. Prescribe drugs, medication or devices not specifically authorized by the supervising physician and documented in the Supervision Agreement; and
- d. Provide a service that exceeds the clinical privileges granted to the supervising physician.

5.9 Infection Prevention

Physicians have an important role in the prevention of nosocomial infection. All practitioners are responsible for complying with Infection Prevention policies/procedures in the performance of their duties. An essential part of this program incorporates patient infection prevention measures as well as systems of barrier precautions. Universal precautions are to be used by practitioners for contact with blood, moist body substances and non-intact skin of all patients, regardless of the patient's diagnosis.

5.10 Clinical Practice Guidelines

Clinical practice guidelines provide a means to improve quality, and enhance the appropriate utilization and value of health care services. Clinical practice guidelines assist practitioners and patients in making clinical decisions on prevention, diagnosis, treatment and management of selected conditions. Clinical practice guidelines can also be used in designing clinical processes, or checking the design of existing processes.

The MEC may adopt evidenced based clinical practice guidelines upon the recommendation of multidisciplinary groups composed of Medical Staff leaders, senior administrative personnel and those health care providers who are expected to implement the guidelines.

The MEC shall consider such sources as the Agency for Health Care Policy and Research, professional medical societies and physician organizations, professional health care organizations, and local organizations. Guidelines shall be adapted to the community, the needs of the patient population, and the resources of the Hospital. Clinical practice guidelines so adopted must anticipate and capture variance.

Section 6. Consent

6.1 Informed Consent for Surgical, Medical or Diagnostic Procedures

6.1.1 Principles of Informed Consent

The patient's right of self-decision can be effectively exercised only if the patient possesses enough information to enable an intelligent choice. The patient should make his or her own determination regarding medical treatment. The practitioner's obligation is to present the medical facts accurately to the patient, or the patient's surrogate decision maker, and to make recommendations for management in accordance with good medical practice. The practitioner has an ethical obligation to help the patient make choices from among the therapeutic alternatives consistent with good medical practice. Informed consent is a process of communication between a patient and the practitioner that results in the patient's authorization or agreement to undergo a specific medical intervention.

6.1.2 General Consent for Inpatient Treatment

A general consent form will be obtained at the time of admission. The Hospital will notify the attending physician whenever such consent has not been obtained. When so notified and except in emergency situations, it will be the attending physician's responsibility to obtain proper consent before the patient is treated in the Hospital.

6.1.3 Documentation of Informed Consent

Except in an emergency, the communication process and the patient's or surrogate decision maker's authorization or agreement for medical procedures and treatments must be documented in the medical record. Please reference the Hospital's Informed Consent Policy for additional requirements.

6.1.4 Waiving Informed Consent in an Emergency

In an emergency situation in which informed consent cannot immediately be obtained from the patient, or surrogate decision maker, a practitioner shall perform those procedures and treatments to the extent permitted by his or her license, which are, in his or her judgment, necessary to preserve the life and health of the patient.

Section 7: Withdrawing and Withholding Life Sustaining Treatment

7.1 Withdrawing and Withholding Life Sustaining Treatment

7.1.1 General Principals

All patients treated in the Hospital should be provided the most complete and best possible care and support, including life-sustaining treatments. Life-sustaining treatment is any treatment that serves to prolong life without reversing the underlying medical condition. Life-sustaining treatment may include, but is not limited to:

- a. Cardiopulmonary resuscitation;
- b. Mechanical ventilation;
- c. Provision of nutrition and hydration through medically or surgically implanted tubes;
- d. Certain invasive procedures;

- e. Dialysis;
- f. Administration of blood and blood products;
- g. Administration of vasopressor agents;
- h. Invasive monitoring; and
- i. Administration of intravenous antibiotics, steroids, chemotherapeutic and immunotherapeutic agents when they serve only to prolong life without reversing the underlying medical condition.

7.1.2 Circumstances for Withholding and Withdrawing Life-Sustaining Treatment

There are circumstances when it is appropriate and ethical to withdraw or withhold life-sustaining treatments in accordance with the wishes, directives, or best interests of the patient. There is no ethical distinction between withdrawing and withholding life-sustaining treatment. A justification that is adequate for not starting a life-sustaining treatment is also sufficient for stopping that treatment. These circumstances include:

- a. **Terminal Illness:** An incurable or irreversible condition that within reasonable medical judgment could cause death within a reasonably short period of time if life-sustaining procedures are not used. Two (2) physicians must examine the patient and certify this fact in the medical record.
- b. **Competent Adults May Refuse Treatment:** A competent, non-pregnant adult with decision-making capacity may refuse life-sustaining therapy.

Section 8: Do Not Resuscitate (DNR) Orders

8.1 Do Not Resuscitate (DNR) Orders

8.1.1 Definitions

- a. "Cardiopulmonary Resuscitation" or "CPR" refers to those procedures and therapies designed to restore breathing and circulation in a patient who has experienced a cardiac or respiratory arrest. Such measures include chest compressions, artificial ventilation, defibrillation, and administration of emergency medications.
- b. "Do Not Resuscitate Order" or "DNR" means a properly recorded and authenticated order by a physician which documents that the patient shall not receive cardiopulmonary resuscitation in the event of a cardiac or respiratory arrest.

8.1.2 Effect of a DNR Order

A DNR order establishes that in the event of cardiac or pulmonary arrest, resuscitation measures will not be implemented. By entering a DNR order into a patient's record, the attending physician warrants and affirms that the patient (or the patient's legal representative when the patient is unable to consent):

- a. Requested or authorized the DNR order; and
- b. Had been fully informed by the physician of the effect of, and potential results from, the DNR order; or that

- c. CPR would be inappropriate or ineffective in the judgment of the attending physician as described in Subsection 7.1.2 and it is not feasible to obtain consent from the patient or legal representative.

A DNR order shall only be valid if the following is documented in the patient's medical record:

- a. A progress note entry documenting that the DNR order was discussed with the patient (or legally authorized representative for a patient unable to consent) who concurs with the order or if Subsection 7.1.2 applies, a progress note entry documenting that CPR would be inappropriate or ineffective; and
- b. An order entry authenticated by the physician stating "Do Not Resuscitate" or "No Code".

8.1.3 Duration of DNR Order

A DNR order shall remain in effect only during the hospital stay and shall become invalid upon the discharge of the patient from the Hospital.

8.1.4 Unclear or Ambiguous DNR Orders

Unclear or ambiguous DNR orders shall not be valid until clarified by the ordering physician.

8.1.5 Verbal and Telephone DNR Orders

Due to the sensitive nature and documentation requirements of DNR orders, such orders must be documented and authenticated in writing by the attending physician (or designee) and may not be conveyed verbally or via telephone except under unusual circumstances and in the manner described below.

- a. Circumstances in Which a Telephone DNR Order is Allowed: A telephone DNR order may be accepted when the patient or surrogate decision maker requests a DNR order but a significant delay will occur by waiting for the physician to document the order in writing and when there is a high probability of cardiopulmonary arrest occurring before the physician's next face-to-face contact with the patient.
- b. Prior Documentation Requirements: In order for a telephone DNR order to be valid, the patient's medical record must already contain the following information:
 - i. Certification of the patient's decision making capacity;
 - ii. Identification of the surrogate decision maker if the patient is not competent; and
 - iii. Documentation that the patient's condition is terminal or that CPR would be inappropriate as described in Subsection 7.1.2.
- c. Procedure for Establishing a Telephone DNR Order: The patient's or surrogate decision maker's agreement and authorization for the order and the physician's telephone DNR order must be conveyed to a registered nurse who shall record in the medical record that he or she was a witness to the communication process.
- d. Subsequent Documentation: The physician must document the rationale for the DNR order as described in Subsection 8.1.5 and countersign the telephone DNR order within twenty-four (24) hours.

Section 9. Disclosure of Unanticipated Outcomes

9.1 Definitions

- a. A "Sentinel Event" is an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof.
- b. A "Medical Error" is an unintended act, either of omission or commission, or an act that does not achieve its intended outcome.
- c. An "Unanticipated Outcome" is a result that differs significantly from the anticipated results of a treatment or procedure, or an outcome which meets the definition of a sentinel event or medical error.
- d. An "Adverse outcome" may be a known risk of a treatment or procedure. An anticipated adverse outcome that is explained to the patient (or their surrogate decision-maker) during the course of obtaining informed consent does not constitute an unanticipated outcome.

9.2 Procedures for Disclosure

- a. In addition to the responsible physician, at least one other Hospital staff person will be present at the time of initial disclosure and at subsequent planned discussions.
- b. The unanticipated outcome should be disclosed to the affected patient and/or the patient's designated representative. If the discussion is anticipated to be complex or difficult, the patient should be encouraged to have another person present during the discussion.
- c. If the patient is deceased, a minor, or deemed to be incapable of understanding the information to be disclosed, the unanticipated outcome should be disclosed to the patient's designated representatives and/or family.

9.2.1 Information That Should Be Provided to the Patient and/or Representative

Patients and their designated representative(s) will be informed of the occurrence of unanticipated outcomes in a truthful and compassionate manner. This disclosure should include:

- a. The time, place, circumstances and definite consequence of the adverse outcome for the patient to the extent known;
- b. The proximate cause of the adverse outcome, if known;
- c. An apology that the adverse outcome occurred;
- d. Assurance that a full analysis will take place;
- e. The name(s) of the individuals who will manage the ongoing care of the patient;
- f. The name(s) of the individuals who will manage ongoing communications with the patient, representative(s) and family, including the names and telephone numbers of individuals at the Hospital who may receive questions, complaints, or concerns;
- g. An invitation to submit a written correspondence or to request additional opportunities to discuss the unanticipated outcome;
- h. The names of other individuals who have been informed of the adverse outcome; and
- i. Internal and external resources that are available to the patient and family for support and counseling.

9.2.2 Documentation

The disclosure of an unanticipated outcome will be documented in the medical record by the responsible physician. This documentation will include:

- a. The time, date, and place of discussion;
- b. The names and relationships of those present (or participating via telephone) including Hospital personnel at the discussion;
- c. Documentation of the discussion of the unanticipated outcome;
- d. Documentation of an offer to be of assistance (including offers for referral) and the response to these offers;
- e. Documentation of any questions proposed by the patient, representative(s) or family and the answers provided by the physician and Hospital personnel; and
- f. Documentation of any follow- up conversations.

Section 10. Restraint and Seclusion

10.1 Restraint and Seclusion

All patients have the right to be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff. Restraint or seclusion may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others and must be discontinued as soon as possible based on an individualized patient assessment and re-evaluation.

10.1.1 Physical Restraint

- a. Physical Restraint is the use of any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of the patient to move his or her arms, legs, body, or head freely. Physical restraints include but are not limited to; mittens (both secured and unsecured), soft restraints, enclosure beds, side-rails, freedom splints, geri-chairs with locked trays.

10.1.2 Chemical/Medication as Restraint

The use of drugs as a restraint may be used, in rare instances should an event occur in which patient, visitor, and/or co-worker safety is in immediate danger. Chemical restraints may be considered as an absolute last remedy.

- a. Drugs utilized as a restraint are defined as follows:
 - i. Medication is used to restrict the patient's freedom of movement;
 - ii. Medication is used as a restriction to manage the patient's behavior; or
 - iii. Medication that is not a standard treatment or dosage for the patient's medical or psychiatric condition.
- b. Standard treatment would include the following and is not considered to be a chemical restraint:
 - i. Medication within pharmacy parameters set by FDA and manufacturer for use;
 - ii. Medication use that follows national practice standards;
 - iii. Medication that is used to treat a specific condition based on patient's symptoms; or
 - iv. Medication that is used as a standard treatment to enable the patient to be effective or function appropriately.

10.1.3 Non-Violent Restraint

A restraint may be necessary to ensure devices providing that the patient who is temporarily or permanently incapacitated will not remove devices providing medical care. Non-violent restraints may be used to limit mobility, or temporarily immobilize a patient related to a medical, post-surgical or post-procedure.

10.1.4 Seclusion

Seclusion is the voluntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving. Seclusion may only be used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member or others.

10.1.5 Non-Violent, Non-Self Destructive Restraint

Prior to consideration being made to apply or utilize any type of restraint, the nurse/physician/APP must complete a comprehensive patient assessment to identify medical symptoms that could be causing behavioral changes. Unless contraindicated for safety purposes, less restrictive alternatives to restraints will be tried or considered and appropriate interventions documented prior to their initiation.

- a. Proper use of a restraint is as follows:
 - i. Restraint shall only be used when less restrictive measures have been found to be ineffective to protect the patient or others from harm.
 - ii. Restraint order must never be written as a standing order or on an "as needed" basis (PRN).
 - iii. Registered Nurse may initiate patient restraint if necessary when the physician/APP is not immediately available. A telephone/verbal order must be obtained within one (1) hour. A telephone/verbal order for restraints must be countersigned by the physician/APP within twenty-four (24) hours.
 - iv. The attending physician must be consulted as soon as possible if restraint or seclusion is ordered by a physician other than attending physician (or designee). The notification of the attending physician may be done by either the nurse or APP which must be documented.
 - v. The initial order for restraint will have a time limited order not to exceed twenty-four (24) hours.
 - vi. Patient's plan of care will be modified to reflect the use of restraints.
 - vii. Restraint will be placed in accordance with safe appropriate restraining techniques.
 - viii. Restraint will be discontinued at the earliest possible time, regardless of the scheduled expiration of the order. Once restraints are removed, a new order must be obtained from the physician/APP if necessary to be reapplied.
 - ix. Authorization for continued use of the restraint beyond the first twenty-four (24) hours is obtained from the physician/APP by renewal of the original order or a new order no less than each calendar day.
 - x. Physician must be notified if more restrictive restraints are necessary.

10.1.6 Violent or Self Destructive Behavior Restraint

Prior to consideration being made to apply or utilize any type of restraints, the nurse/physician/APP must complete a comprehensive patient assessment to identify medical symptoms that could be causing behavioral changes. Consideration must be given to pre-existing medical conditions or a history of abuse that may cause an increase in violent or self-destructive behavior that may occur during restraint/seclusion. Regardless of patient setting, such emergencies generally pose a significant risk for patients and others. In these situations, the use of restraint may be necessary to manage the patient's violent or self-destructive behavior when less restrictive interventions have been determined to be ineffective to protect the patient, staff or others from harm.

- a. Proper use of a restraint is as follows:
 - i. Restraint shall only be used when less restrictive measures have been found to be ineffective to protect the patient or others from harm.
 - ii. Non-physical techniques will be considered as the preferred intervention in violent management.
 - iii. Registered Nurse may initiate patient restraint if necessary when the physician/APP is not immediately available. A telephone/verbal order must be obtained immediately after the initiation of the restraint.
 - iv. Restraint order must never be written as a standing order or on an "as needed" basis (PRN).
 - v. Restraint orders are time limited according to the patient's age.
 - vi. A physician/APP shall evaluate the patient face-to-face within one (1) hour after restraints are applied in order to identify ways to help the patient regain control and make any necessary revisions to the written plan of care.
 - vii. After the face-to-face evaluation is completed and the continued need for restraint use is determined, the nurse will call to renew order as follows:
 - Every four (4) hours for patients age 18 and older;
 - Every two (2) hours for patients ages 9 to 17;
 - Every one (1) hour for patients under age 9.
 - viii. If a restraint is still indicated after twenty-four (24) hours, the physician/APP must conduct an additional face-to-face evaluation before issuing a new order.
 - ix. Patient's plan of care will be modified to reflect the use of restraints.
 - x. If the restraint is removed or discontinued prior to the expiration of the order, a new order must be obtained prior to reapplying the restraint and all requirements need to be repeated.
 - xi. After the restraint is discontinued, a debriefing will be conducted with the patient.
 - xii. If the restraint resulted in injuries to the patient, the physician will be contacted.

Section 11. Research

11.1 Investigational Studies

The Institutional Review Board must approve in advance, investigational studies and clinical trials conducted at the Hospital. When patients are asked to participate in investigational studies, informed consent must be obtained and documented as described in Section 5.2 including:

- a. Documentation that the patient has been given sufficient information to make an informed decision;

- b. Expected benefits;
- c. Potential discomforts or risks;
- d. Alternative therapies that might be of benefit;
- e. Procedures to be followed; and
- f. That the patient has been informed that their refusal to participate will not affect their access to Hospital services.

Section 12. Surgical Care

12.1 Surgical Privileges

A member of the Medical Staff may perform surgical or other invasive procedures in the surgical suite or other approved locations within the Hospital as approved by the MEC. Surgical privileges will be delineated for all practitioners performing surgery in accordance with the competencies of each practitioner.

12.2 Surgical Policy and Procedural Manual

All practitioners shall comply with the Hospital's Surgical Policy and Procedures Manual. The manual will cover the following:

- a. Procedure for scheduling surgical and invasive procedures (including priority, loss of priority, change of schedule, and information necessary to make reservations);
- b. Emergency procedures;
- c. Requirements prior to anesthesia and operation;
- d. Care and transport of patients;
- e. Use of operating rooms;
- f. Contaminated areas;
- g. Conductivity and Environmental Control; and
- h. Radiation safety procedures.

12.3 Moderate or Deep Sedation/Anesthesia

The following individuals, who have been granted clinical privileges to perform these services, may only provide moderate or deep sedation and anesthesia:

- a. An anesthesiologist;
- b. A doctor of medicine or osteopathy other than an anesthesiologist;
- c. A doctor of dental surgery or dental medicine;
- d. An oral maxillofacial surgeon
- e. A podiatrist; or
- f. A certified registered nurse anesthetist (CRNA) supervised by the operating practitioner or anesthesiologist;

The anesthesiologist/anesthetist will maintain a complete anesthesia record (to include evidence of pre-anesthetic evaluation and post-anesthetic follow-up) of the patient's condition for each patient receiving moderate or deep sedation and anesthesia.

12.4 Assisting Surgeon

In any surgical or invasive procedure with unusual hazard to life, there will be a qualified assisting practitioner scrubbed and present unless the patient's life is in jeopardy and a qualified practitioner is not immediately available.

12.5 Surgical Specimens

12.5.1 Laboratory tests on all patients admitted to the Hospital shall consist of those needed to make an appropriate diagnosis.

12.5.2 All specimens removed during surgery will be subject to the Laboratory policies/procedures addressing the examination of the specimen. These policies/procedures are located in the Operational Policy and Procedure Manual and are as follows:

- a. Policy #344: Specimens Exempted from routine or mandatory submission.
- b. Policy #345: Specimens that qualify for tracking under the "Safe Medical Devices Act of 1990."
- c. Policy #346: Specimens Exempted from Microscopic Examination

12.5.3 The Pathologist will make such examination as may be considered necessary to obtain a diagnosis. The pathologist's report will be made part of the patient's medical record.

Section 13. Emergency Services

13.1 Responsibility for Examination and Stabilization of Patient:

Mercy Hospital Joplin has a responsibility to provide any individual presenting to the Hospital with an emergency condition appropriate medical screening examinations within the scope of the Hospital's capability, including ancillary services routinely available. The Hospital will also provide stabilizing treatment within its capacity, which minimizes the risks to the individual's health, and in the case of a woman in labor, the health of the unborn child. Every effort will be made to carry out the above stated responsibilities unless:

- a. The patient refuses treatment or request's a transfer; or
- b. The medical benefits of transfer outweigh the medical risks of transfer and a transfer is appropriate.

13.2 Examination and Treatment

Individuals presenting to the Hospital for emergency conditions are entitled to examination and stabilizing treatment regardless of their ability to pay. Examination and treatment may not be delayed in order to inquire about the patient's insurance or payment status.

13.3 Medical Screening

A medical screening examination is the process required to reach, with reasonable clinical confidence, the point at which it can be determined whether the individual has an emergency medical condition or not. A

medical screening examination is not an isolated event. It is an ongoing process that begins, but typically does not end, with triage.

13.4 Individuals Authorized to Perform Initial Medical Screening:

The following are authorized to conduct the initial medical screening for an emergency medical condition when an individual presents to the Hospital:

- a. Medical Staff Members
- b. Emergency Trauma Center Registered Professional Nurses
- c. Labor & Delivery Triage Registered Professional Nurses
- d. Psychiatric Evaluation Nurses
- e. Advanced Practice Nurses
- f. Physician Assistants

13.5 Qualified Personnel Authorized to Perform Stabilizing Treatment:

The following personnel are qualified and authorized to perform stabilizing treatment:

13.5.1 Pre-Hospital Services

- a. Emergency Medical Technicians
- b. Paramedics
- c. Emergency Trauma Center Registered Professional Nurses

13.5.2 Emergency Trauma Center

- a. Paramedics
- b. Emergency Trauma Center Registered Professional Nurses
- c. Emergency Trauma Center Physicians
- d. Patient's attending physician
- e. Advanced Practice Nurses
- f. Physician Assistants

13.6 Transfers and/or Refusal of Treatment:

13.6.1 A patient with an unstable emergency/medical condition may be appropriately transferred in cases where the patient (or the person acting on the patient's behalf) requests the transfer or the physician certifies the medical necessity of the transfer.

13.6.2 The emergency room physician and/or the attending physician has the responsibility to fully explain to the patient (or person acting on the patient's behalf) the risks and benefits of either an examination and treatment or transfer, and to take all reasonable steps to secure the patient's (or person acting on behalf of the patient) written consent for transfer or refusal of treatment.

13.6.3 In cases of transfer, the facility that will receive the patient must have qualified personnel and space to treat the patient and must have agreed to accept the patient.

- 13.6.4 Copies of all available medical records including copies of test results which relate to the patient's emergency medical condition and signed consent forms and/or the physician's certification to transfer will be sent with the patient.
- 13.6.5 The transfer must be affected through qualified personnel and transportation equipment, including life support equipment if medically necessary and appropriate. Mercy Hospital Joplin's physicians (and not the receiving hospital) have the responsibility to determine the appropriate mode, equipment and attendants for transfer.
- 13.6.6 The appropriate consent form(s) must be complete, including a summary of the risks and benefits of the transfer and signed by the physician. These forms are to be part of the medical record and copies of the forms must accompany the patient being transferred.
- 13.6.7 The patient (or the person acting on the patient's behalf) will be kept informed of the details of the transfer arrangements including the medical capabilities of the receiving facility and the name of the receiving physician.
- 13.6.8 No patient with an emergency medical condition will be sent to any physician's office or transferred until they have been treated and stabilization of their emergency medical condition has been achieved. This will be waived if a competent patient or person responsible for a patient has made an informed decision (including consideration of the risks and benefits of such a transfer) to request transfer or discharge from the Emergency Trauma Center, including leaving against medical advice (AMA). Appropriate documentation will be completed for all such transfers or AMA discharges.

13.7 Medical Record

An appropriate medical record shall be kept for every patient receiving emergency medical services and be incorporated in the patient's hospital record. The record shall include:

- a. Adequate patient identification;
- b. Information concerning the time of the patient's arrival, means of arrival and by whom transported;
- c. Pertinent history of the injury or illness including details relative to first aid or emergency care given the patient prior to his or her arrival at the hospital.
- d. Description of significant clinical, laboratory and radiologic findings;
- e. Diagnosis;
- f. Treatment given;
- g. Condition of the patient on discharge or transfer; and
- h. Final disposition, including instruction given to the patient and/or the patient's family, relative to necessary follow-up care.

13.8 Mass Casualties

There shall be a plan for the care of mass casualties at the time of any major disaster based upon the Hospital's capabilities in conjunction with other emergency facilities in the community. It shall be developed by the Emergency Preparedness Committee and be approved by Administration and the MEC.

Section 14. Radiology and Nuclear Medicine Services

14.1 General Radiology

14.1.1 The MEC approves the qualifications of the radiology staff that use equipment and administer procedures.

14.2 Nuclear Medicine

14.2.1 The MEC approves the nuclear services director's specifications for the qualifications, training, functions, and responsibilities of the nuclear medicine staff.

Section 15: Psychiatric Services

15.1 General Rules Regarding Psychiatric Procedures

There shall be written orders including justification for the following special treatment procedures:

- a. Electroconvulsive and other forms of convulsive therapy;
- b. Psychosurgery or other surgical procedures to alter or intervene in an emotional, mental or behavioral disorder; and
- c. Behavior modification procedures that use aversive conditioning.

Section 16. Adoption and Approval

The Medical Staff Bylaws of Mercy Hospital Joplin have been approved and adopted as listed below:

05/11/2016

EXHIBIT C



Cohen, Melissa <melissa.cohen@ppfa.org>

FW: Staff Privileges and Hospital Bylaws at Cox Health

1 message

Eisenberg, David [REDACTED]
To: "Cohen, Melissa" <melissa.cohen@ppfa.org>

Tue, Sep 13, 2016 at 4:28 PM

[REDACTED]

[REDACTED]

From: [REDACTED]@coxhealth.com]
Sent: Monday, September 12, 2016 4:32 PM
To: [REDACTED]
Cc: [REDACTED]@coxhealth.com>
Subject: Staff Privileges and Hospital Bylaws at Cox Health

hi Dr Eisenberg –

Attached are the Bylaws for CoxHealth...

[REDACTED]

Medical Staff Specialist, Medical Staff

[REDACTED]

[REDACTED]

coxhealth.com



From: Eisenberg, David [REDACTED]
Sent: Monday, September 12, 2016 12:00 PM
To: [REDACTED]
Subject: Staff Privileges and Hospital Bylaws at Cox Health

Good Morning,

I am writing to request a copy of your facility's staff bylaws, as I am interested in what the requirements are to apply for staff privileges. For your convenience, I have attached a copy of my CV to this email. If you could please forward any relevant credentialing documents on to me I would appreciate it.

Sincerely,

David L. Eisenberg, MD, MPH, FACOG

Medical Director

Planned Parenthood of the St. Louis Region and Southwest Missouri

&
Associate Professor
Washington University in St. Louis School of Medicine
Department of Obstetrics & Gynecology

[REDACTED]
St. Louis, MO 63110

[REDACTED]
[REDACTED]



Planned Parenthood of the St. Louis Region and Southwest Missouri

ADVOCATES - The Political Arm of Planned Parenthood of the St. Louis Region and Southwest Missouri

4251 Forest Park Avenue St. Louis, MO 63108

http://secure-web.cisco.com/1wSDE9Z54ZsEochya-QsWA_DNTg_ICLtEtu5WHDS3hNU_4W_cgM5VkokSUrPeW2kkzt48jRg2uekg7GffO8QTITgoxiMAWKamDGwQqSddCiYGlP8Gp7WWX78NT4NuwjMt7W32zZCBT627XhuTqnbjQiy-ICApSibT3SEaipcm962V3i2XB-hEQPqDscocZRUGhUXiLydPAIUv4tFOWZPIQ3wOhLUT2iRA_HUr5emr2KZVLUiXEopVWzJ5ryy6phV44qnWJfkVeYecsun2LA3qXETJpiYMdTu_82RCHHbly-2MxZeNrW-fWuPDusU8dUA0/http%3A%2F%2Fwww.plannedparenthood.org%2Fstlouis

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 Bylaws.pdf
776K



Cohen, Melissa <melissa.cohen@ppfa.org>

FW: Staff Privileges and Hospital Bylaws at Cox Health

1 message

Eisenberg, David [REDACTED]
To: "Cohen, Melissa" <Melissa.Cohen@ppfa.org>

Sat, Jan 28, 2017 at 11:15 AM

From: [REDACTED]@coxhealth.com]
Sent: Monday, September 12, 2016 12:09 PM
To: Eisenberg, David
Subject: RE: Staff Privileges and Hospital Bylaws at Cox Health

You have a very impressive CV. Are you interested in positions we have at Cox? Two of our groups are recruiting for an additional partner. I would love to pass along your information if you would be interested in speaking with them. [REDACTED] will send you our Med staff guidelines.

[REDACTED]

Administrative Director Physician Recruitment, Cox Health

[REDACTED]

[REDACTED]

coxhealth.com



From: Eisenberg, David [REDACTED]
Sent: Monday, September 12, 2016 12:00 PM
To: [REDACTED]
Subject: Staff Privileges and Hospital Bylaws at Cox Health

Good Morning,

I am writing to request a copy of your facility's staff bylaws, as I am interested in what the requirements are to apply for staff privileges. For your convenience, I have attached a copy of my CV to this email. If you could please forward any relevant credentialing documents on to me I would appreciate it.

Sincerely,

David L. Eisenberg, MD, MPH, FACOG

Medical Director

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&
Associate Professor
Washington University in St. Louis School of Medicine
Department of Obstetrics & Gynecology

[Redacted]
St. Louis, MO 63110

[Redacted]
[Redacted]



Planned Parenthood of the St. Louis Region and Southwest Missouri

ADVOCATES – The Political Arm of Planned Parenthood of the St. Louis Region and Southwest Missouri

4251 Forest Park Avenue St. Louis, MO 63108

[Redacted]

http://secure-web.cisco.com/1nufbBv6e3f4iofNIWd3JwFPixgg9XvWsu35WQPI9kiJHAlm-yiSeJb3R2ze38aVMB4ynQN7QWY07Vny3esWai0w_zPnlMVJ73mEzhEcNt1JcgbgJztzvPjFiVtJPUqT5sCAhHygLiXsJz3x9GCqUr9naA9w9_mEmY2UXXFnCAoEfrB_6OFK4OGVRXQjzkA8HyXIEC3qbP-5atybctlmdmEbchf6lg1xGHZlTrLb-ia4Vxg1d8bXdOSracObuUE_qc-QZGF2YSfo-e2R0HarSaYF9U0qF5-Lybeg43LJXHU3WRGXf5eyb8U19CIzbg/http%3A%2F%2Fwww.plannedparenthood.org%2Fstlouis

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Eisenberg, David

From: Eisenberg, David
Sent: Monday, September 19, 2016 10:54 AM
To: [REDACTED]
Subject: RE: Staff Privileges and Hospital Bylaws at Cox Health

Hi [REDACTED],

Thank you for the follow up. I am not interested in full-time employment, but am exploring opportunities to provide clinical care in the Springfield area at the Planned Parenthood Health Center.

Please let me know if you have additional questions.

Best regards,

David L. Eisenberg, MD, MPH, FACOG
Medical Director
Planned Parenthood of the St. Louis Region and Southwest Missouri
&
Associate Professor
Washington University in St. Louis School of Medicine
Department of Obstetrics & Gynecology

[REDACTED]
St. Louis, MO 63110
[REDACTED]

From: [REDACTED]@coxhealth.com]
Sent: Saturday, September 17, 2016 9:24 AM
To: Eisenberg, David [REDACTED]
Subject: Re: Staff Privileges and Hospital Bylaws at Cox Health

Are you interested in employment from Cox? We do have an opening.

Sent from my iPhone

[REDACTED]
Administrative Director Physician Recruitment, Cox Health
[REDACTED]

coxhealth.com



On Sep 12, 2016, at 12:01 PM, Eisenberg, David [REDACTED] wrote:

Good Morning,

I am writing to request a copy of your facility's staff bylaws, as I am interested in what the requirements are to apply for staff privileges. For your convenience, I have attached a copy of my CV to this email. If you could please forward any relevant credentialing documents on to me I would appreciate it.

Sincerely,

David L. Eisenberg, MD, MPH, FACOG
Medical Director
Planned Parenthood of the St. Louis Region and Southwest Missouri
&
Associate Professor
Washington University in St. Louis School of Medicine
Department of Obstetrics & Gynecology

[REDACTED]
[REDACTED]
St. Louis, MO 63110
[REDACTED]
[REDACTED]

<image001.jpg>

4251 Forest Park Avenue St. Louis, MO 63108
[REDACTED]

http://secure-web.cisco.com/1nufbBv6e3f4iofNIWd3JwFPixgq9XvWsu35WQPI9kiJHAlm-yiSeJb3R2ze38aVMB4ynQN7QWY07Vny3esWai0w_zPnIMVJ73mEzhEcNt1JcgbgJztzvPjFiVtJPUqT5sCAhHygLiXSJz3x9GCqUr9naA9w9_mEmY2UXXFnCAoEfrB_6OFK4OGVRXQjzkA8HyXIEC3qbP-5atybctImdmEbchf6lg1xGHziTrLb-ia4Vxg1d8bXdOSracObuUE_qc-QZGF2YSfo-e2R0HarSaYF9U0qF5-Lybeg43LJXHUs3WRGXf5eyb8U19Clzbg/http%3A%2F%2Fwww.plannedparenthood.org%2Fstlouis

<Eisenberg_CV_12Sep2016.pdf>

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Lester E. Cox Medical Centers

Springfield Hospitals

MEDICAL STAFF

BYLAWS

**BYLAWS OF THE MEDICAL STAFF OF LESTER E. COX MEDICAL CENTERS
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ARTICLE 1

ADOPTION

- A.** These Medical Staff Bylaws are adopted and made effective upon approval by the Medical Staff and the Board of Directors of the Corporation, superseding and replacing any and all previous Medical Staff Bylaws, and henceforth all activities and actions of the Medical Staff and of each individual exercising Clinical Privileges at the Hospital shall be taken under and pursuant to the requirements of these Bylaws.
- B.** These Bylaws, together with the Medical Staff Rules and Regulations, establish a framework for self-governance of Medical Staff activities and accountability, and, together with the Credentialing Procedures Manual, shall establish the procedures and requirements for appointment to the Medical Staff and granting of Clinical Privileges and events and actions affecting such Privileges. The Bylaws and Medical Staff Manuals are intended to be dynamic and evolving, as medical science and the standards of the Hospital, Medical Staff, and operations of the Hospital, change from time to time, and as may be necessary to comply with changes in the law and Joint Commission Standards.
- C.** The present Credentialing Procedures Manual and Rules and Regulations are hereby readopted and placed into effect insofar as they are consistent with these Bylaws, until such time as they are amended. To the extent they are inconsistent, the Credentialing Procedures Manual and Rules and Regulations are of no force or effect pertaining to the subject matter thereof.

ADOPTED BY THE MEDICAL STAFF ON

Date

Mary Duff, MD
Medical Staff President

ADOPTED BY THE BOARD ON

Date

Joseph W. Turner
Board of Directors, Chair

ARTICLE 2

DEFINITIONS

A. DEFINITIONS

The following definitions shall apply to terms used in these Bylaws:

- 1) **“ACCREDITED RESIDENCY”** when used with respect to training obtained by a Physician means a postgraduate residency-training program, which has been accepted by the American Board of Medical Specialties or the American Osteopathic Association to make the residency graduate eligible for board certification. A Physician will be deemed to have satisfied these requirements if the last full year of his/her residency training is from such an approved or accredited program.
- 2) **“ACCREDITED FELLOWSHIP”** when used with respect to training obtained by a Physician means a post-residency subspecialty training program, which has been approved by the ACGME and is listed as accredited in the Directory of Graduate Medical Education Programs published by the ACGME for the year the applicant’s fellowship was completed.

A Physician will be deemed to have satisfied these requirements if the last full year of his/her fellowship training is from such an approved or accredited program.

- 3) **“ALLIED HEALTH PROFESSIONALS” “AHP”** means and refers to those classes of health care professionals, other than Physicians and Specialty Dentists, whose skills and knowledge have been determined by the Board to be needed for the care of patients in the Hospital, who have been licensed or certified by their respective licensing or certifying Missouri state agencies (if applicable) to provide care independently or under the supervision of Members of the Medical Staff, and who may be granted, on an individual basis, Clinical Privileges/services by the Board. Allied Health Professionals may be employees of the Hospital, independent providers or employees of Members of the Medical Staff. Examples of Allied Health Professionals include clinical psychologists, advanced practice nurses, podiatrists, physician assistants, nurses employed by Members of the Medical Staff, Resident Physicians, and General Dentists.
- 4) **“ALLIED HEALTH PROFESSIONAL MANUAL”** means the Allied Health Professional Manual adopted by the Medical Executive Committee and approved by the Board, as amended from time to time.
- 5) **“APPLICANT”** means a Physician or Specialty Dentist applying for or inquiring about an application for Medical Staff appointment at the Hospital, including teaching and research services.
- 6) **“BOARD”** means the Board of Directors of the Corporation, which is the governing body of the Corporation and which has overall responsibility for the conduct of the Hospital and shall include, where appropriate, committees of the Board of Directors

designated to act on behalf of the Board of Directors with respect to a particular function or duty.

- 7) **“BOARD CERTIFIED”** or **“BOARD CERTIFICATION”** means the certification by a Specialty Board which is recognized or certified by 1) the American Board of Medical Specialties; 2) the American Osteopathic Association Bureau of Osteopathic Specialists or 3) the American Dental Association in one or more of the following specialty areas of dentistry: Prosthodontics, Endodontics, Oral and Maxillofacial Surgery, Orthodontics, Pediatric Dentistry, Periodontology, (or any other specialty area of dentistry that has been recognized by the American Dental Association), all requiring at least two (2) years of additional education in an academic program approved by the American Dental Association. Each Physician/Specialty Dentist must have satisfactorily passed the examination and meet other criteria of such Specialty Board for such certification.
- 8) **“BOARD ELIGIBLE”** means that a physician has completed the requirements for admission to a medical specialty board but has not passed that examination.
- 9) **CHIEF EXECUTIVE OFFICER “CEO”** means the officer who is appointed by the Board to act on its behalf in the overall administrative management of the Hospital.
- 10) **“CLINICAL PRIVILEGES”** or **“PRIVILEGES”** means the permission granted by the Board to an Applicant, Member or, as applicable, an Allied Health Professional to render or perform specific diagnostic, therapeutic, medical, dental or surgical procedures as specifically delineated to such Applicant, Member or Allied Health Professional.
- 11) **“CORPORATION”** means Lester E. Cox Medical Centers, a Missouri pro forma corporation, which is governed by the Board.
- 12) **“CREDENTIALING PROCEDURES MANUAL”** means the Credentialing Procedures Manual adopted by the Medical Executive Committee and approved by the Board, as amended from time to time.
- 13) **“CREDENTIALS COMMITTEE”** means the committee of the Medical Staff that reports to the MEC and is comprised of a representative from each department and the VPMA. The Credentials Committee’s purpose is to review relevant data regarding appointments and reappointments to the Medical Staff, as appropriate, as well as delineation of Clinical Privileges for Applicants and Members.
- 14) **“EPISODES OF CARE”** means admitting, consulting, treating, interpreting/reading studies, or performing procedures on an inpatient or outpatient during any inpatient admission or outpatient encounter (e.g. If patient A receives an outpatient endoscopy procedure, this constitutes one Episode of Care. If patient B is admitted to the Hospital two weeks later for a surgical procedure, and the Consulting Physician performs the procedure, rounds on the patient every day for three days and discharges patient, this inpatient admission constitutes one Episode of Care). Rounding does not constitute an Episode of Care.

- 15) **“EX OFFICIO”** means a member of a committee by virtue of such member holding an office or position and, unless otherwise expressly provided, has no voting rights.
- 16) **“GENERAL DENTIST”** means a doctor of dental medicine who has graduated from a four (4) year general dentistry school that is approved by the American Dental Association and has a current dental license or is in the process of obtaining a dental license issued by the Missouri Dental Board.
- 17) **“HOSPITAL”** means the hospital facilities located at 3801 South National Avenue, 1423 North Jefferson, and 1000 E. Walnut Lawn, Springfield, Missouri and their outpatient departments.
- 18) **“JOINT COMMISSION”** means the Joint Commission, formerly the Joint Commission on Accreditation of Healthcare Organizations, or its successor.
- 19) **“MEDICAL EXECUTIVE COMMITTEE” “MEC”** means the committee of the Medical Staff comprised of the elected representatives of the Medical Staff, authorized to act on behalf of the Medical Staff except when otherwise specified.
- 20) **“MEDICAL STAFF”** means the collective body of all Physicians and Specialty Dentists who are appointed thereto by the Board, subject to the Medical Staff Manuals, and who may be granted Privileges to treat patients at the Hospital or provide other diagnostic, therapeutic, teaching or research services at the Hospital.
- 21) **“MEDICAL STAFF MANUALS”** means and refers to these Bylaws, the Rules and Regulations and the Credentialing Procedures Manual, as amended from time to time.
- 22) **“MEDICAL STAFF OFFICE”** means and refers to the office established by the Hospital to process applications for appointment or reappointment to the Medical Staff or for Clinical Privileges, including verifying and collecting information.
- 23) **“MEMBER”** means any Physician or Specialty Dentist who has been granted current Medical Staff appointment to one of the categories listed in Article 6 and who may have Clinical Privileges granted by the Board to practice at Hospital.
- 24) **“PEER REVIEW COMMITTEE”** means the Medical Staff committee comprised of the VPMA, Medical Staff President, President-Elect, appropriate department chair(s) and any other individuals the committee deems appropriate for the purpose of reviewing the individual Member’s professional performance, clinical competence, and behavioral issues to establish performance improvement objectives with the goal of improving patient care.
- 25) **“PHYSICIAN”** means both a doctor of medicine (“M.D.”) and a doctor of osteopathy (“D.O.”) who has a current license or is in the process of obtaining a license issued by the State Board of Registration for the Healing Arts of the State of Missouri to practice medicine and surgery. For the purpose of these Bylaws, this definition shall not include Resident Physicians, as defined herein.

- 26) **“RESIDENT PHYSICIAN”** means a Physician who is in the process of completing an Accredited Residency.
- 27) **“RULES AND REGULATIONS”** means the Rules and Regulations as adopted by the MEC and approved by the Board, as amended from time to time.
- 28) **“SPECIAL NOTICE”** means written notification which is given or sent by certified or registered mail, postage prepaid, return receipt requested or by personal delivery. When directed to an Applicant or Member, Special Notice shall mean the correspondence is addressed to his/her last office address on file with the Medical Staff Office.
- 29) **“SPECIALTY BOARD”** means that certifying agency or board relating to a medical or dental specialty (or subspecialty) as recognized or authorized by the American Board of Medical Specialties, the American Osteopathic Association Bureau of Osteopathic Specialists or the American Dental Association to issue certificates of special recognition of Physicians’ or Specialty Dentists’ training and expertise in a specialty or subspecialty.
- 30) **“SPECIALTY DENTIST”** means a General Dentist that has continued his/her education with advanced knowledge and skills, and is Board Certified in one or more of the following specialty areas of dentistry that have been recognized by the American Dental Association: Prosthodontics, Endodontics, Oral and Maxillofacial Surgery, Orthodontics, Pediatric Dentistry, Periodontology, or any other specialty area of dentistry that has been recognized by the American Dental Association, all requiring at least two (2) years of additional education in an academic program approved by the American Dental Association and who has a current specialty license or is in the process of obtaining a specialty license issued by the Missouri Dental Board. Specialty Dentist shall also include those General Dentists who have been grandfathered under Article 3, Section 2.g.
- 31) **“TELEMEDICINE”** means the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. It may be performed by a telemedicine entity or distant-site hospital simultaneously (real time) or non-simultaneously (after the fact).
- 32) **VICE PRESIDENT OF MEDICAL AFFAIRS “VPMA”** means a Physician approved by the CEO to act as the Chief Administrative Medical Officer of the Hospital.

Words used in these Bylaws shall be read as the masculine or feminine gender, and as the singular or plural, as the content requires. The captions or headings are for convenience only and are not intended to limit or define the scope or effect of any provision of these Bylaws.

ARTICLE 3

BASIC MINIMUM REQUIREMENTS FOR APPOINTMENT

A. BASIC MINIMUM REQUIREMENTS FOR APPOINTMENT

Appointment to the Medical Staff is a privilege which shall be extended only to professionally competent Applicants who meet the qualifications, standards, and requirements applicable to the category of the Medical Staff to which appointment is sought in accordance with the Medical Staff Manuals.

Unless otherwise provided by the Medical Staff Manuals, all Applicants who may provide treatment, care or consultations to patients in the Hospital must first satisfy the basic minimum requirements (“Basic Minimum Requirements”) listed in this Article 3 in order to receive an application to be considered for appointment on the Medical Staff.

In the event the Applicant fails to meet the Basic Minimum Requirements for appointment set forth herein, an application will not be processed, and the Applicant shall have no right to a hearing or appeal. No Applicant shall be permitted to reapply for Medical Staff appointment for one (1) year from the date such application was rejected by the Medical Staff Office for failure to meet Basic Minimum Requirements, unless the VPMA and the Medical Staff President agree.

1. TRAINING/EDUCATION

- a. Physicians must have successfully completed an Accredited Residency and/or fellowship in the specialty in which he/she principally seeks Privileges.
- b. Dentists must be Specialty Dentists.

2. CERTIFICATION

- a. Applicants must currently be Board Certified in the specialty in which he/she principally seeks Clinical Privileges (which for these purposes shall mean subspecialty if the Applicant’s practice is principally in a Board Certified subspecialty); or
- b. Applicants must be Board Certified in the specialty in which he/she principally seeks Clinical Privileges (which for these purposes shall mean subspecialty if the Applicant’s practice is principally in a Board Certified subspecialty) within five (5) years of completing an Accredited Residency or Accredited Fellowship in the specialty (or subspecialty as addressed above) in which he/she principally seeks Clinical Privileges.

If a Member or Applicant does not become Board Certified within five (5) years of completing an Accredited Residency or Accredited Fellowship, but is currently Board Eligible in the specialty in which he/she principally seeks Clinical Privileges (which for these purposes shall mean subspecialty if the

Applicant's or Member's practice is principally in a Board Certified subspecialty), the Applicant or Member may request an extension to achieve Board Certification for a specified period of time, not to exceed twenty-four (24) months. The Applicant or Member must submit his/her request for an extension in writing to the VPMA and Medical Staff President, including a timeline that specifies plans for becoming Board Certified. The VPMA and Medical Staff President may approve the Applicant's or Member's request for extension. This extension may be renewed upon approval of the VPMA and Medical Staff President for one additional time period not to exceed twenty-four (24) months, so long as the Member or Applicant remains Board Eligible and in the process of obtaining Board Certification.

The above requirement that Applicants shall be Board Certified or Board Eligible, may be waived (and such Applicants may be granted Medical Staff membership) for patient care needs due to shortages in the Medical Staff by unanimous approval of the Credentials Committee, MEC, and the Board.

- c. Notwithstanding the above, a Member's Medical Staff appointment will be immediately terminated without right to hearing or appeal if the Member is not Board Certified within five (5) years of completing an Accredited Residency or Accredited Fellowship as set forth above.
- d. If a Member who was appointed to the Medical Staff ceases to be Board Certified in the specialty in which the Member principally practices (which shall, for these purposes, refer to a subspecialty if the Member's practice is principally in a subspecialty that has a Specialty Board) because the Member failed to become recertified by his/her Specialty Board within the time required by the particular Specialty Board to maintain certification, then the Member must take and pass the applicable recertification test within eighteen (18) months of the lapse of certification. If the Member fails to take and pass the applicable recertification test within such eighteen (18) month period, then his/her appointment shall terminate immediately without any right to a hearing or appeal.
- e. If a Member has more than one Board Certification (e.g. Internal Medicine, Pulmonology and Critical Care) and would like to let one or more of his/her Board Certifications lapse because Member's practice is no longer principally in the Board Certified specialty/subspecialty at issue, Member must first receive approval from the Board upon recommendation by the Credentials Committee and MEC.
- f. Under exceptional circumstances such as lack of available Board Certification in Member's specialty or subspecialty, the Board may approve an alternate form of certification (e.g. Certificate of Added Qualifications) if recommended by both the Credentials Committee and the MEC,
- g. General Dentists who were not Specialty Dentists as of January 1, 2008, but who were Members of the Medical Staff as of that date may remain on the Medical Staff so long as General Dentists continue to satisfy all requirements for Medical Staff appointment.
- h. The requirement to be Board Certified as set forth in this Section 2 shall be waived for Members who were on the Medical Staff as of January 1, 2000.

3. OTHER SPECIFIC QUALIFICATIONS

Applicants must:

- a. have not been convicted of, pleaded guilty to a charge of, or entered a plea of no contest to a charge of, a felony which reasonably relates to the ability of the Applicant to exercise the Clinical Privileges sought to be granted, whether or not sentence was imposed;
- b. have not been excluded from any government funded program of healthcare, such as, but not limited to, the Medicare or Medicaid programs or TRICARE (formerly CHAMPUS).

4. MEDICAL TREATMENT OF APPLICANT OR MEMBER AT HOSPITAL

Applicant and Member agree, acknowledge and consent that if Hospital examines or provides treatment or care to an Applicant or Member for a medical condition that raises a reasonable question as to whether Applicant or Member is able to provide medical care within the Hospital without posing a threat to the safety or health of any patient, other Member, AHP, employee of the Hospital or any other person in the Hospital, then such information may be disclosed to the Peer Review Committee (or its designee) and to Hospital for the purpose of evaluating Applicant's ability to satisfy the requirements for appointment or Member's continued qualification to safely perform his/her Clinical Privileges.

5. NONDISCRIMINATION

Hospital will not discriminate in granting appointment or Privileges on the basis of age, sex, race, color, disability, national origin or religion unrelated to the provision of patient care.

ARTICLE 4

APPOINTMENT AND REAPPOINTMENT PROCESS

A. APPOINTMENT

All requests for an application for appointment to the Medical Staff will be submitted to the Medical Staff Office. Only those Applicants who satisfy the Basic Minimum Requirements for appointment to the Medical Staff as set forth in Article 3, Section A are eligible to receive an application for appointment to the Medical Staff. However, an Applicant may still receive an application if he/she has not yet obtained a Missouri license or is still finishing his/her residency.

Notwithstanding, even if an Applicant satisfies the Basic Minimum Requirements for Appointment, no application shall be furnished to any Applicant requesting Privileges or appointment where the Hospital has entered into an exclusive contract for the provision of certain professional services or where the Hospital has elected not to provide the service in which the Applicant seeks privileges.

If an Applicant is denied an application for failure to satisfy the Basic Minimum Requirements for Appointment or, if Applicant is provided an application and it is later determined that the Applicant fails to satisfy the Basic Minimum Requirements for Appointment, the Applicant shall have no right to a hearing or appeal.

1. APPLICATION PROCESS

- a. Each Applicant seeking appointment to the Medical Staff shall submit an application to the Medical Staff Office and shall contain information in response to all questions, including, but not limited to, the following:
 - (i) Basic Minimum Requirements (See Article 3);
 - (ii) Experience, ability and current competency;
 - (iii) Privileges requested;
 - (iv) Practice and previous hospital experience;
 - (v) Any unfavorable history regarding licensure and hospital Privileges; and
 - (vi) Such other information as the Board may require as set forth in the Medical Staff Manuals.
 - (vii) Valid professional liability insurance coverage in such form, with such insurers and in such amounts as are satisfactory to the Board or that Applicant provides sufficient proof that such insurance will be in place on the date Member is appointed to the Medical Staff.
- b. After the Medical Staff Office receives an application, it will review the application, verify information submitted, and may request additional information from the Applicant. An application shall be considered a completed application when all of the following have occurred (“Completed Application”):

- (i) all questions on the application have been answered;
- (ii) collection and verification has been completed; and
- (iii) all requested additional information has been provided.

c. Burden of Providing Information

- (i) The Applicant shall have the burden of producing information for a proper evaluation of his/her competence, character, ethics and other qualifications, and of resolving any doubts about such qualifications, including specifically information from other hospitals, and information concerning malpractice actions and disciplinary or competency investigations or actions, as the Medical Staff or any committee thereof or committee of any applicable department may request in order to provide appropriate quality assurance review.
- (ii) The Applicant shall have the burden of providing evidence that all the statements made and information given on the application are true and correct.
- (iii) Until the Applicant has provided all information requested, the application for appointment will be deemed incomplete and will not be processed, except for such limited review or processing by the Medical Staff Office as may be necessary. Should information provided in the initial application form change during the course of the appointment term, the Member has the burden to provide sufficient information about such change to the Medical Staff Office as soon as reasonably possible.

d. The Medical Staff Office shall then send the Completed Application and any additional information to the following, for review and recommendation including approving or rejecting Applicant's application for initial appointment, requesting additional information or granting or denying Clinical Privileges:

- (i) the appropriate section/department chair for review and recommendation to the MEC;
- (ii) VPMA for review and recommendation to the MEC;
- (iii) Credentials Committee chair for review and recommendation to the MEC;
- (iv) Medical Staff President on behalf of the MEC for review and recommendation to the Board; and
- (v) Board or the designated committee of the Board as applicable, in accordance with such specific procedures as may be established by the Board including accepting or rejecting the MEC's recommendation or remanding the matter back to the MEC for further investigation or consideration.

The Board must take action on an application within six (6) months of the date on which it became a Completed Application.

An application shall become incomplete if the need arises for new, additional or clarifying information anytime during the evaluation. Any application that continues to be incomplete sixty (60) days after the Applicant has been notified by the Medical Staff Office of the failure to provide the information requested shall be deemed to be withdrawn with no right to hearing or appeal. It is the responsibility of the Applicant to provide a Completed Application, including adequate responses from references.

e. No Automatic Entitlement to Appointment

No Applicant shall be entitled to appointment to the Medical Staff or a specific category of the Medical Staff, and no Applicant shall be entitled to the exercise of particular Clinical Privileges in the Hospital merely by virtue of the fact that such Applicant:

- (i) is licensed to practice a profession in the State of Missouri or any other state;
- (ii) is a member of any particular professional organization;
- (iii) has had in the past, or currently has, medical staff appointment or privileges at any hospital;
- (iv) resides in the geographic service area of the Hospital; or
- (v) satisfies the threshold requirements or qualifications for appointment set forth in Article 3 as set forth herein.

f. Board has Ultimate Responsibility for Authority for Appointment

Pursuant to Missouri law (including applicable regulations) and Joint Commission standards, the Board has the ultimate responsibility and authority with respect to making appointments to the Medical Staff and granting of Clinical Privileges, and the Board may also consider in addition to whether the Applicant satisfies the qualifications for appointment, or the effect appointment of the Applicant would have on Hospital operations, or administration, the effect on Hospital's reputation, or any other factor in addition to the Applicant's competence and qualifications which the Board determines in its discretion may adversely affect the best interests of patient care or the operations of Hospital. Notwithstanding, in exercising its authority, the Board shall not consider as a factor whether an Applicant has an ownership interest in or affiliation with a facility that provides services that competes with Hospital.

2. TERMS OF APPOINTMENT/REAPPOINTMENT

Appointments/reappointments to the Medical Staff shall be made by the Board, upon recommendation by the MEC. Terms of appointment/reappointment for each category of the Medical Staff are as follows:

Active	not to exceed 2 years
Active Provisional	not to exceed 2 years
Consulting	not to exceed 2 years
Consulting Provisional	not to exceed 2 years
Affiliate	not to exceed 2 years

A Member shall be transitioned from Provisional to Active or Consulting upon successful completion of the Provisional period and upon approval by the Board. If the Member’s performance is not satisfactory at the end of the Provisional period, then the Member shall not be transitioned to Active or Consulting. In such case, the Member shall be entitled to the rights, if any, set forth in Article 12 of these Bylaws.

B. REAPPOINTMENT

1. The Medical Staff Office shall notify a Member that his/her appointment to the Medical Staff will expire within six (6) months prior to the date of expiration of the appointment term.

Prior to the Credentials Committee meeting (at which a recommendation will be made regarding the reappointment of the particular Member), the Member shall submit a reappointment application and supporting documentation in writing to the Medical Staff Office. The reappointment application shall contain information in response to all questions on such application.

After the Medical Staff Office receives a reappointment application, it will review the application, verify information submitted, request additional information from the Member if needed, and will notify the Member of any inadequacies or verification issues. The Member shall then have the burden of producing adequate information and resolving any doubts about the information provided. An application shall be considered a completed reappointment application when all of the following have occurred (“Completed Reappointment Application”):

- a. all questions on the application have been answered;
- b. collection and verification have been completed; and
- c. all requested additional information has been provided.

A reappointment application shall become incomplete if the need arises for new, additional or clarifying information anytime during the evaluation. If the Member has failed to provide the additional information requested after first receiving notice from

the Medical Staff Office of the need for the additional information, Member's application for reappointment shall be deemed to be withdrawn unless the MEC determines otherwise. It is the responsibility of the Member to provide a complete reappointment application.

2. BURDEN OF PROVIDING INFORMATION

- a. Upon request of the Medical Staff Office, the Member shall have the burden of producing information for a proper evaluation of his/her competence, character, ethics and other qualifications, and of resolving any doubts about such qualifications, including specifically information from other hospitals, and information concerning malpractice actions and disciplinary or competency investigations or actions, as the Medical Staff or any committee thereof or committee of any applicable department may request in order to provide appropriate quality assurance review.
- b. The Member shall have the burden of providing evidence that all the statements made and information given on the application are true and correct.
- c. Should information provided in the initial reappointment application form change during the course of the appointment term, the Member has the burden to provide sufficient information to the Medical Staff Office about such change as soon as reasonably possible.

3. After the reappointment application is completed, the Medical Staff Office shall send such Completed Reappointment Application and any additional information to the following for review and recommendation including approving or rejecting Member's application for reappointment, requesting additional information, modification of the reappointment period; or granting, denying, modifying or revoking Clinical Privileges or dismissal from the Medical Staff.

- a. The Appropriate section/department chair, for review and recommendation to the MEC;
- b. VPMA, for review and recommendation to the MEC;
- c. Credentials Committee Chair, for review and recommendation to the MEC;
- d. Medical Staff President, on behalf of the MEC, for review and recommendation to the Board;
- e. Board or the designated committee of the Board as applicable, in accordance with such specific procedures as may be established by the Board including accepting or rejecting the MEC's recommendation or remanding the matter back to the MEC for further investigation or consideration.

The Board must take action on a reappointment application within six (6) months of the date on which it became a Completed Reappointment Application, but in no event may the Board consider any reappointment application after the Member's expiration of current appointment/reappointment.

4. NO AUTOMATIC ENTITLEMENT TO REAPPOINTMENT

No Member shall be entitled to reappointment to the Medical Staff or a specific category of the Medical Staff, and no Member shall be entitled to the exercise of particular Clinical Privileges in the Hospital merely by virtue of the fact that such Member:

- a. is licensed to practice a profession in the State of Missouri or any other state;
- b. is a member of any particular professional organization;
- c. currently has medical staff appointment or privileges at any hospital, including this Hospital;
- d. is currently a Member of the Medical Staff in a staff category which has or provides no Clinical Privileges at this Hospital; or
- e. resides in the geographic service area of the Hospital.

5. BOARD HAS ULTIMATE RESPONSIBILITY FOR AUTHORITY FOR REAPPOINTMENT

Pursuant to Missouri law (including applicable regulations) and Joint Commission standards, the Board has the ultimate responsibility and authority with respect to making reappointments to the Medical Staff and granting of Clinical Privileges and the Board may also consider in addition to whether the Member satisfies the basic qualifications for reappointment, or the effect reappointment of the Member would have on Hospital operations, or administration, the effect on Hospital's reputation, or any other factor in addition to the Member's competence and qualifications which the Board determines in its discretion may adversely affect the best interests of patient care or the operations of Hospital. Notwithstanding, in exercising its authority, the Board shall not consider as a factor whether a Member has an ownership interest in or affiliation with a facility that provides services that competes with Hospital.

C. DELEGATED CREDENTIALING

In lieu of the procedures set forth in this Article 4, the Medical Staff may delegate the credentialing and privileging process to telemedicine entities or distant-site hospitals where the Hospital has an agreement with that telemedicine entity or distant-site hospital for the performance of contracted medical services.

1. The telemedicine entity or distant- site hospital shall perform all services consistent with the applicable Center for Medicare Medicaid Services (CMS) Conditions of Participation related to credentialing and privileging.
2. The telemedicine entity or distant-site hospital shall utilize credentialing and privileging processes and standards that meet or exceed Hospital's standards. The Credentials Committee shall determine whether the telemedicine entity or distant-site hospital is qualified to perform delegated credentialing. If the telemedicine entity or distant-site hospital credentialing process does not meet Hospital's standards, the practitioner shall be credentialed using Hospital's standard credentialing procedures.
3. The Board may grant privileges based on Medical Staff recommendations which have been formed on the basis of credentialing and privileging information provided by the telemedicine entity or distant-site hospital.

ARTICLE 5

CLINICAL PRIVILEGES

A. GENERAL INFORMATION REGARDING CLINICAL PRIVILEGES

Applicants and Members exercise only those Clinical Privileges that are within the scope of their current licensure and are granted by the Board upon recommendation by the MEC.

Neither Medical Staff appointment nor reappointment shall confer any Clinical Privileges or right to practice at the Hospital. Each Member who has been appointed to the Medical Staff shall be entitled to exercise only those Clinical Privileges specifically granted by the Board.

The granting of Clinical Privileges shall carry with it acceptance of the obligations of such Privileges including emergency department call and other rotational obligations as set forth in the Medical Staff Manuals.

The Clinical Privileges recommended to the Board may be based upon consideration of the following:

1. the existence of criteria for the requested Clinical Privileges which have been approved by the Board;
2. the Applicant's or Member's ability to meet all Medical Staff criteria approved by the Board for the requested Clinical Privileges;
3. the Applicant's or Member's relevant education, training, experience, demonstrated current clinical competence and clinical judgment, references, recommendations of peers, current licensure, utilization patterns, and ability to perform the essential functions of the Privileges requested, with or without reasonable accommodation, without posing a direct threat to the health or safety of the Applicant or Member, patients or others;
4. recommendations and evaluations received from the Applicant's or Member's peers and peer review evaluations, if any, from other hospitals;
5. availability of qualified Physicians or other appropriate Members to provide medical coverage for the Applicant or Member in case of the Applicant's or Member's illness or unavailability;
6. adequate levels of professional liability insurance coverage with respect to the Clinical Privileges requested;
7. the Hospital's available resources and personnel;
8. any previously successful or currently pending challenges to any licensure or registration, or the voluntary relinquishment of such licensure or registration;
9. any information concerning the voluntary or involuntary termination of medical staff appointment or the voluntary or involuntary limitation, reduction, or loss of Clinical Privileges at another hospital;
10. any information concerning current or recent professional liability claims involving the Applicant or Member;
11. whether the Hospital has determined to perform the procedures relating to the Clinical Privileges sought by the Applicant or Member;
12. whether the privileges are the subject of any exclusive contractual arrangements of the Hospital; and
13. other relevant information, including, but not limited to, a written report and findings by the chair of each of the clinical departments in which such Privileges are sought.

The Applicant or Member shall have the burden of establishing that he/she satisfies the requirements for, and competence to exercise, the Clinical Privileges requested.

No Applicant or Member is eligible to request initial or additional Privileges where the Hospital has elected not to provide the service in which the Applicant or Member seeks privileges.

B. INITIAL PRIVILEGES

Each Applicant, as part of his/her initial application process, shall request those specific Clinical Privileges which he/she wishes to exercise within the scope of his/her medical or dental license. It is the Applicant's burden to provide objective evidence of current competence and satisfaction of the requirements or qualifications in the appropriate clinical area(s).

To the extent that an Applicant requests a Clinical Privilege for new or existing technology or equipment that is not already a part of the then-existing Privileges approved by the Board, then such potential Clinical Privilege or procedure must be evaluated and approved by Hospital's technology assessment process. If the new or existing technology or equipment is approved, then the Medical Staff Office shall allow the Applicant to continue the privileging process with respect to requested Clinical Privileges for the new or existing technology or equipment.

C. RENEWAL OF CLINICAL PRIVILEGES AT REAPPOINTMENT

If, at the time of a Member's reappointment, the Member has failed to satisfy the criteria established by the Credentials Committee to perform a Clinical Privilege which had been granted to the Member, the Member may request that the Credentials Committee allow him/her to continue to perform said Privilege. Upon receipt of the request, the Credentialing Committee may, in its sole discretion:

1. recommend continuation of the Privilege; and/or
2. require proctoring of the performance or exercise of the Privilege; and/or
3. recommend to the MEC that the Privilege be removed.

D. REVISION OF CLINICAL PRIVILEGES

A request for deletion of or addition of Clinical Privileges shall be submitted in writing to the Medical Staff Office and must meet the criteria outlined in the Credentialing Procedures Manual. It is the Member's burden to provide objective evidence of current competence and satisfaction of the requirements or qualifications in the appropriate clinical area(s).

To the extent that a Member requests a Clinical Privilege for new or existing technology or equipment that is not already a part of the then-existing Privileges approved by the Board, then, such potential Clinical Privilege or procedure must be evaluated and approved by Hospital's technology assessment process. If the Privilege for new or existing technology or equipment is approved, then the Medical Staff Office shall allow the Member to continue the privileging process with respect to the new or existing technology or equipment.

E. TIMEFRAME FOR NOTIFICATION OF DECISION

Applicants or Members shall be notified within twelve (12) weeks of a decision to grant, limit, or deny an initially requested or existing Privilege.

F. TEMPORARY PRIVILEGES

Temporary privileges shall not routinely be granted to Physicians, Specialty Dentists, and Allied Health Professionals and shall only be granted in the circumstances and under the conditions described below. Under all circumstances, the Physician, Specialty Dentist, or Allied Health Professional requesting temporary privileges must agree in writing to abide by the Medical Staff Bylaws, Rules and Regulations, and policies of the Hospital in all matters relating to his/her activities in the Hospital.

A. Important Patient Care Need

Temporary privileges may be granted in extraordinary unplanned situations when necessary to avoid undue hardship to the Hospital or the Medical Staff, including fulfilling an important patient care need. It is within the sole discretion of the VPMA to determine whether an important patient care need exists and, thus, whether the Physician, Specialty Dentist, or Allied Health Professional will receive an application.

Prior to granting such Privileges, the Medical Staff Office must receive a completed application, verification of current Missouri licensure, current competency, DEA, BNDD, certification (if applicable), professional liability insurance, character, ethical standing, National Practitioner Data Bank, copy of his/her driver's license or other Photo I.D. and signed confidentiality statement.

B. New Applicants

Temporary privileges may be granted to an Applicant who has satisfied the requirements for appointment set forth in Article 4 but has not yet had his/her completed application reviewed by the MEC for recommendation to the Board. It is within the sole discretion of the VPMA to determine whether an Applicants application should be considered for temporary privileges.

Temporary privileges may be granted for a period not to exceed one hundred twenty (120) days. To be eligible for temporary privileges, there must be no evidence of current or previously successful challenge to licensure or registration; no adverse criminal history, have not been subject to involuntary termination of medical staff membership or allied health professional staff membership at another organization; or involuntary limitation, reduction, denial, or loss of clinical privileges.

Temporary Privileges as set forth above may only be granted by the Board on recommendation of the following:

1. VPMA or Credentials Committee Chair
2. Medical Staff President or Department Chair
3. CEO or his/her designee

The granting of any temporary privileges is a courtesy on the part of the Hospital. The Board may, at any time after receiving a recommendation from the Medical Staff President, VPMA, Credentials Committee chair, or the chair of the department responsible for the Applicant's supervision, terminate temporary privileges. The granting, denial or termination of temporary privileges shall not entitle the Physician or Specialty Dentist to any of the procedural rights provided in Article 12.

G. LOCUM TENENS

A Locum Tenens is a contracted physician who provides recurring, short-term care for the specific purpose to temporarily fulfill the duties of another physician; i.e. vacations, scheduled time off, etc. Requests for a Locum Tenens must come from a physician or group whose practitioners are on staff at the hospital or from a hospital based service to fulfill a service need. Locum Tenens physicians must provide the same information as applicants for initial appointment to the Medical Staff and complete a delineation of privileges form for the appropriate specialty or specialties. Privileges are limited to a period of six (6) months with the possibility of renewal for an additional six (6) months based on an ongoing need. If the Locum Tenens physician's service is required for a longer period of time, the physician may be considered for appointment to the Active/Consulting staff on a case-by-case basis. Locum Tenens physicians are not members of the medical staff and are not eligible to vote, hold office, serve on medical staff committees, may not proctor other physicians and do not pay membership dues. The granting, denial, or termination of privileges shall not entitle the Locum Tenens Physician to any of the procedural rights provided in Article 12.

H. TELEMEDICINE PRIVILEGES

Licensed Independent Practitioners who use electronic telecommunications or other communication technologies to provide or support clinical care from a distance may apply for telemedicine privileges. Providers shall be licensed in Missouri and must provide the same information as applicants for initial appointment to the Medical Staff. The Board has the option when considering granting privileges to telemedicine physicians, to have the hospital's medical staff rely upon the credentialing and privileging decisions of the distant site hospital in lieu of the traditional credentialing and privileging process required in Article 4 of these bylaws.

The Delegated Credentialing agreement shall include the methods of obtaining credentialing, privileging, and quality data information (Article 4: C. Delegated Credentialing). Licensed Independent Practitioners with the sole purpose to provide telemedicine services are not members of the medical staff, do not have admitting privileges, shall not be required to attend meetings, vote, hold office, or pay annual medical staff dues. The granting, denial, or termination of privileges shall not entitle the telemedicine provider to any of the procedural rights provided in Article 12.

I. OBSERVING (NO PATIENT CONTACT)

A Physician or Specialty Dentist who will have no patient contact must provide to the Medical Staff Office a copy of his/her Driver's License or other Photo ID, and signed Confidentiality Statement.

J. EMERGENCY CLINICAL PRIVILEGES

1. "Emergency" is defined as the condition which could result in serious or permanent harm to a patient(s) and in which any delay in administering treatment would add to that harm or danger.
2. In an emergency, an Applicant who has been granted temporary Clinical Privileges may be permitted to exercise Clinical Privileges as appropriate to avoid the immediate danger of harm to the patient. When the emergency situation no longer exists, Applicant's emergency Privileges shall expire, and the patient shall be assigned by the Medical Staff President or designee to a Member with appropriate Clinical Privileges. The wishes of the patient shall be considered in the selection of a substitute Member.

3. Similarly, in an emergency, a Member currently appointed to the Medical Staff having Clinical Privileges may act in such emergency by exercising Clinical Privileges not specifically granted to that Member if within the scope of such Member's individual license to address the immediate danger or harm to the patient. When the emergency situation no longer exists, Member's emergency Privileges shall expire and the patient shall be assigned by the Medical Staff President or designee to a Member with appropriate Clinical Privileges. The wishes of the patient shall be considered in the selection of a substitute Member.
4. The procedures described in this Section are not intended to serve as, and shall not serve as, a method for granting temporary Privileges except as to a specific patient under the emergency circumstances described in this Section.

K. DISASTER PRIVILEGES

Disaster Privileges are granted only when the following two conditions are present:

1. Emergency Management Plan has been activated, and
2. The organization is unable to meet immediate patient need.

1. MEDICAL STAFF MEMBERS AND APPLICANTS WITH TEMPORARY CLINICAL PRIVILEGES

In case of a disaster and/or emergency, any Medical Staff Member or an Applicant who has been granted temporary Clinical Privileges, to the extent permitted by his/her license (and regardless of Medical Staff category, department assignment, or Clinical Privilege delineation) may, and indeed should, assist in the care of the patient. The CEO or his/her designee(s) or the Medical Staff President or his/her designee(s) may in his/her sole discretion, grant, deny or terminate disaster Privileges.

2. PHYSICIAN AND/OR SPECIALTY DENTIST VOLUNTEERS

Disaster Privileges may be granted to volunteers considered eligible to act as licensed independent Physicians and/or Specialty Dentists who, at a minimum have 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. Current hospital picture ID card;
 - b. Current license to practice;
 - c. Primary source verification of the license which begins as soon as the immediate situation is under control, and is completed within seventy-two (72) hours from the time the volunteer presents;
 - d. Identification indicating the individual is a member of a DMAT (disaster medical assistance team) or MRC (Medical Reserve Corp.), ESAR-VHP (The Emergency System for Advance Registration of Volunteer Health Professionals), or other recognized state or federal organizations or groups;
 - e. Identification badge indicating the individual has been granted authority to render patient care, treatment and services in disaster circumstances (such authority having been granted by a federal, state or municipal entity); or
 - f. Identification by current hospital or medical staff Members(s) with personal knowledge regarding Applicant's identity.
3. Each volunteer granted disaster Privileges shall be required to practice under the supervision of a Member of the Medical Staff. A decision will be made within the seventy-two (72)

hours related to the continuation of the disaster Privileges initially granted. When the immediate situation has passed and the determination has been made consistent with the Hospital's Emergency Management Plan, the volunteer's disaster Privileges will terminate immediately.

4. The granting of disaster Privileges is a courtesy on the part of the Hospital. The granting, denial or termination of such disaster Privileges shall not entitle the Member or Volunteer to any of the procedural rights provided in Article 12. (See Medical Staff Disaster Plan for operational details).

L. SPECIAL CONDITIONS FOR SPECIALTY DENTISTS' PRIVILEGES

Requests for Clinical Privileges from Specialty Dentists are processed in the manner specified in this Article. Surgical procedures performed by Specialty Dentists are under the overall supervision of the chair of the department of surgery. All patients of Specialty Dentists (except patients of Oral and Maxillofacial surgeons) shall receive a basic medical appraisal by a Physician Member of the Medical Staff. A Physician Member of the Medical Staff shall also be responsible for the care of any medical problem that may be present at admission or that may arise during hospitalization and shall advise on the risk and effect of any proposed surgical or special procedure on the total health status of the patient. When significant medical issues are present, the final decision on whether to proceed with the surgery must be agreed upon by the Specialty Dentist and the Physician Member. The chair of surgery will decide the issue in case of dispute.

M. PRIVILEGES WHERE HOSPITAL IS UNDER AN EXCLUSIVE CONTRACT

No Applicant or Member is eligible to request initial or additional Privileges where the Hospital has entered into an exclusive contract for the provision of certain hospital-based professional services as more fully defined in the Credentialing Procedures Manual. The Credentialing Procedures Manual shall, among other things, identify the specialties subject to an exclusive Hospital contract and shall address the effect an exclusive contract has on a Member's Clinical Privileges and appointment. As set forth in Article 10, Section F, the Credentialing Procedures Manual may be amended by a majority vote of the members of the MEC present and voting at any meeting of the MEC where a quorum exists, and no amendment to the Medical Staff Manuals shall be effective until it has been approved by the Board.

N. LIMITED PRIVILEGES FOR NON-MEDICAL STAFF MEMBERS AND ALLIED HEALTH PROFESSIONALS TO ORDER OUTPATIENT DIAGNOSTIC AND THERAPEUTIC SERVICES

Physicians and Specialty Dentists who order, but will not perform at Hospital or any of its outpatient departments, outpatient diagnostic or therapeutic services, and who are not Members of the Medical Staff, and Allied Health Professionals who are not credentialed by the Medical Staff Office, shall be granted limited Clinical Privileges to order outpatient diagnostic or therapeutic services at the Hospital, provided that an appropriate designee of Hospital documents the following prior to Hospital's acceptance of the order:

- a. Physician, Specialty Dentist or Allied Health Professional's current state license; and
- b. Office of Inspector General (OIG) List of Excluded Individuals/Entities.

The limited privileges granted to such Physician, Specialty Dentist or Allied Health Professional shall not exceed the scope and authority of his/her current state license or practice act.

ARTICLE 6

FUNCTIONS AND CATEGORIES OF THE MEDICAL STAFF

A. PURPOSE

The purpose of the Medical Staff is to organize the activities of qualified Physicians and Specialty Dentists who practice at the Hospital in order to carry out, in conformity with these Bylaws, the functions delegated to the Medical Staff by the Board. The Medical Staff provides oversight of care, treatment, and services provided by Members and AHPs with Privileges at the Hospital. The Members of the Medical Staff work together as an organized body to promote a uniform standard of quality patient care, treatment, and services and to offer advice, recommendations, and input to the CEO and the Board.

B. QUALIFICATIONS FOR APPOINTMENT

Qualifications for appointment are set forth in the Medical Staff Manuals.

C. RESPONSIBILITIES AND FUNCTIONS OF THE MEDICAL STAFF

Medical Staff Members have the following responsibilities and functions:

1. Initiating, developing, approving and amending these Bylaws;
2. Enforcing and complying with the these Bylaws;
3. Providing oversight for the quality, care, treatment, and services provided by Members;
4. Accountability to the Board;
5. Selecting and removing Medical Staff officers;
6. Determining the mechanism for establishing and enforcing criteria and standards for Medical Staff appointment;
7. Determining the mechanism for establishing and enforcing criteria for delegating oversight responsibilities to Members with Privileges;
8. Determining the mechanism for establishing and maintaining patient care standards and credentialing and delineation of Clinical Privileges;
9. Providing leadership for measuring, assessing and improving processes through the following integrated performance improvement initiatives:
 - a. Education of patients and families;
 - b. Coordination of care, treatment and services of our patients;
 - c. Accurate, timely and legible completion of patient's medical records;
 - d. Responsibility for the focused and ongoing evaluations of a Member's competence; and
 - e. Communication of findings, conclusions, recommendations and actions to improve performance to appropriate Staff Members and the Board;
10. Developing criteria used for evaluating the performance of Members when issues affecting the provision of safe, high quality patient care are identified;

11. Developing criteria for an expedited process for appointment to the Medical Staff;
12. Developing criteria for an expedited process for granting Privileges;
13. Developing a fair hearing and appeal process addressing quality of care issues;
14. Provides oversight in the process of analyzing and improving patient satisfaction.

D. CATEGORIES OF THE MEDICAL STAFF

The Medical Staff shall be divided into the following categories:

1. Active
2. Consulting
3. Affiliate
4. Honorary

All Members shall be appointed to a primary department, and those Members in the Active and Consulting categories will be initially placed on Provisional status for a period not to exceed two (2) years.

All appointments to the Medical Staff shall be made by the Board in accordance with these Bylaws and the Credentialing Procedures Manual.

1. ACTIVE MEDICAL STAFF

a. Qualifications

Active Medical Staff shall consist of Members, who satisfy the terms set forth in this Section:

b. Provisional Medical Staff Status

Active Provisional Medical Staff status is reserved for Physicians or Specialty Dentists who are not on the Active Medical Staff as of the date of application. Active Provisional Medical Staff status is granted for a period not to exceed two (2) years. Active Provisional Members must first undergo proctoring as established by the Credentials Committee before transitioning to the Active Medical Staff category.

c. Successful Completion of Proctoring

Upon successful completion of the proctoring process, the Member will be transitioned to the Active Medical Staff, as applicable.

d. Roles and Responsibilities

All Active Medical Staff Members (including those Members with Provisional status) shall have the following roles and responsibilities:

- (i) may vote on all matters presented at general and special meetings of the Medical Staff and of the department, sections and committees of which he/she is a member unless otherwise disqualified or as provided by the MEC or the Medical Staff Manuals;
- (ii) may hold office, serve as department chair, and serve on Medical Staff committees;
- (iii) Provisional Active Medical Staff Members may not hold office, or serve as a department chair;
- (iv) attend to patients, perform procedures or otherwise participate in the treatment and care of patients within the limits of the Clinical Privileges granted to them in accordance with the Medical Staff Manuals and applicable policies of the Hospital, Medical Staff and applicable department/section;
- (v) participate in focused professional practice evaluations to establish competency for Clinical Privileges requested as necessary;
- (vi) identify an alternate Member of the Medical Staff having equivalent Clinical Privileges upon whom Member can rely (and who has agreed) to provide coverage or back-up (including Emergency Department call coverage for unassigned patients) for Member's patients if Member is otherwise unavailable for Member's patients;
- (vii) provide Emergency Department call coverage for their own patients (either personally or via a call partner or call group) within the limits of the Clinical Privileges granted to them in accordance with the Medical Staff Manuals and applicable policies of the Hospital, Medical Staff and department;
- (viii) participate in quality improvement, peer review and patient monitoring activities including the supervision and evaluation of Members (including those on Provisional status); notwithstanding, Active Provisional Members cannot supervise or evaluate other Members (including those on Provisional status) until their Provisional period has ended;
- (ix) engage in the Hospital's and Medical Staff's teaching and continuing education programs;
- (x) pay application fees and Medical Staff dues;
- (xi) accept and/or seek consultations when requested;
- (xii) maintain in force professional liability insurance that is not less than the minimum amounts as established by the Board upon the advice of the MEC;
- (xiii) maintain in good standing the Member's license to practice medicine and surgery or dentistry, as applicable, in the State of Missouri;
- (xiv) comply with the Medical Staff Manuals and the policies of the Hospital, Medical Staff and applicable department/section to which the Member is appointed and fulfill all of the obligations required of such department's/section's members;
- (xv) complete patient medical records as specified in the Medical Staff Manuals;
- (xvi) perform history and physicals according to the Medical Staff Manuals,

- applicable policies of the Hospital, Medical Staff and applicable department;
- (xvii) complete the Medical Staff Conflict of Interest Disclosure Statement as required by the MEC and/or the Board; and
 - (xviii) comply with the Hospital's Compliance Plan and Code of Conduct.
 - (xix) attend mandatory corporate compliance training as determined by MEC and/or Board; and
 - (xx) participation in Ethics, Futile Care and related committees where such committees are reviewing the care provided to Member's patient.

2. CONSULTING MEDICAL STAFF

a. Qualifications

Consulting Medical Staff shall consist of Members who have fifty (50) or less Episodes of Care during any rolling twelve (12) month period beginning on the date of appointment/reappointment, and otherwise satisfy the terms set forth in this Section;

b. Provisional Medical Staff Status

Provisional Medical Staff status is reserved for Physicians or Specialty Dentists who are not on the Consulting Medical Staff as of the date of application. Consulting Provisional Medical Staff status is granted for a period not to exceed two (2) years. Consulting Provisional Members must first undergo proctoring as established by the Credentials Committee before transitioning to the Consulting Medical Staff category.

c. Successful Completion of Proctoring

Upon successful completion of the proctoring process, the Member will be transitioned to the Consulting Medical Staff, as applicable.

d. Request for Consulting Staff Appointment

Applicants who want to join the Consulting Medical Staff must make such request prior to the application process. The Credentials Committee shall review the request for Consulting Medical Staff appointment, and its decision shall be final and binding with no right to a hearing or appeal. If an Applicant fails to request Consulting Medical Staff appointment within the timeframe set forth herein, he/she may not again request Consulting Medical Staff appointment until completion of the Provisional period.

e. Automatic Transition to Active Medical Staff Due to More Than 50 Episodes of Care - Request for Reconsideration

If the Consulting Medical Staff Member has more than fifty (50) Episodes of

Care in a rolling twelve (12)-month period at the Hospital, Member will be automatically transitioned to the Active Medical Staff.

Member may send a written request to the Medical Staff Office, care of the Credentials Committee chair, requesting reconsideration of the transition to Active Medical Staff. The written request must be received by the Medical Staff Office before the next scheduled Credentials Committee meeting.

The Credentials Committee will thereafter make a recommendation to the MEC. The MEC shall consider the recommendation and shall thereafter make a recommendation to the Board. The Credentials Committee, MEC and/or Board may request the Member to provide additional information regarding his/her Episodes of Care or other related information. The Member shall remain on the Consulting Staff until the Board makes its final decision. The Board's decision shall be final and binding, and Member shall have no right to a hearing or appeal.

f. Failure to Timely Request Reconsideration

Failure to timely submit a request to the Medical Staff Office, in care of the Credentials Committee chair, before the next scheduled Credentials Committee meeting or to provide the additional information requested within thirty (30) days of the request for such information will result in a waiver of the Member's right to request reconsideration, and the Member shall remain a Member of the Active Staff until the next reappointment period (or completion of the Provisional period, if applicable) when Member may request a transfer back to Consulting Medical Staff.

g. Failure To Satisfy Requirements for Active Medical Staff

If a Member is unable to satisfy the requirements of Active Medical Staff appointment (e.g. no call coverage), the Member may resign from the Medical Staff or request transfer to the Affiliate Medical Staff. If the Member fails to do either within fourteen (14) days of notification of the Board's decision, the Member will be placed on a leave of absence from the Medical Staff for a period not to exceed sixty (60) days from expiration of the fourteen (14)-day period. If Member fails to satisfy the requirements of Active Medical Staff, resign from the Medical Staff or request transfer to the Affiliate Medical Staff within the sixty (60)-day leave of absence period, Member shall be deemed to have voluntarily resigned from the Medical Staff with no right to a hearing or appeal. Member may not reapply for Medical Staff appointment for one (1) year unless the VPMA and Medical Staff President agree.

h. Members With Consulting Provisional Status

If a Member has more than fifty (50) Episodes of Care during a rolling twelve (12)-month period at the Hospital during the Member's Provisional Consulting period, Member will be automatically transitioned to the Provisional Active Staff for the remainder of his/her Provisional period subject to the other rights and obligations set forth above in this Section.

i. Roles and Responsibilities

All Consulting Medical Staff Members (including those Members with Provisional status) shall have the following roles and responsibilities:

- (i) may attend and participate in Medical Staff and department meetings but may not vote on Medical Staff or department issues whether the issues are presented for vote at a Medical Staff or department meeting or by ballot;
- (ii) may be appointed and/or invited to serve on committees (with vote);
- (iii) have responsibility within the Member's areas of professional competence and Clinical Privileges for timely and continuous care and supervision within generally recognized standards of care of the Member's patients in the Hospital for whom the Member is providing services, or arranges for another appropriately qualified Member of the Medical Staff to provide such services;
- (iv) cannot hold office;
- (v) identify an alternate Member of the medical Staff having equivalent Clinical Privileges upon whom Member can rely (and who has agreed) to provide coverage or back-up for Member's patients if Member is otherwise unavailable for Member's patients;
- (vi) participate in quality improvement, peer review and patient monitoring activities;
- (vii) pay application fees and Medical Staff dues;
- (viii) maintain in force professional liability insurance in not less than the minimum amounts as established by the Board upon the advice of the MEC;
- (ix) maintain in good standing the Member's license to practice medicine and surgery or dentistry, as applicable, in the State of Missouri;
- (x) comply with the Medical Staff Manuals and the policies of the Hospital, Medical Staff and applicable department to which the Member is appointed and fulfill all of the obligations required of such department's/section's Members;
- (xi) complete patient medical records as specified in the Medical Staff Manuals;
- (xii) perform history and physicals according to the Medical Staff Manuals, applicable policies of the Hospital, Medical Staff and department;
- (xiii) complete the Medical Staff Conflict of Interest Disclosure Statement as required by the MEC and/or the Board;
- (xiv) comply with the Hospital's Compliance Plan and Code of Conduct;
- (xv) attend mandatory corporate compliance training as determined by MEC

- and/or Board; and
- (xvi) participation in Ethics, Futile Care and related committees where such committees are reviewing the care provided to Member's patient.

3. AFFILIATE MEDICAL STAFF

Affiliate Medical Staff shall consist of Members who are typically, but not always, office-based and have no Hospital activity. These Members may not admit, consult, treat, or perform procedures in Hospital. Affiliate Medical Staff Members must satisfy the terms set forth in this Section.

a. Roles and Responsibilities

All Affiliate Medical Staff Members shall have the following roles and responsibilities:

- (i) may participate in the Hospital's and Medical Staff's teaching and continuing education programs;
- (ii) pay application fees and Medical Staff dues;
- (iii) maintain in force professional liability insurance in not less than the minimum amounts as, from time to time, may be established by the Board upon the advice of the MEC;
- (iv) maintain in good standing the Member's license to practice medicine and surgery or dentistry, as applicable, in the State of Missouri;
- (v) may not hold office or serve on standing Medical Staff Committees and shall not be eligible to vote;
- (vi) perform history and physicals in their offices according to the Medical Staff Manuals, applicable policies of the Hospital, Medical Staff and department;
- (vii) comply with the Medical Staff Manuals and the policies of the Hospital, Medical Staff and applicable department/section to which the Member is appointed and fulfill all of the obligations required of such department's/section's Members;
- (viii) attend mandatory corporate compliance training as determined by MEC and/or Board.

Any request by a Member of the Affiliate Medical Staff to transfer to the Active or Consulting Medical Staff must first satisfy the requirements set forth in this Article 6.

4. HONORARY STAFF

The Honorary Staff designation is to recognize certain Physicians or Specialty Dentists who are of outstanding reputation and who have retired from actively practicing medicine or dentistry.

a. Qualifications

Honorary Staff appointees shall consist of Physicians or Specialty Dentists:

- (i) who have retired from practice; and
- (ii) who are of outstanding reputation; and
- (iii) who are not current Members of the Medical Staff.

The MEC has the authority to recommend a Physician or Specialty Dentist for the Honorary Staff designation subject to approval by the Board.

Appointment to the Honorary Staff is discretionary and may be revoked by the Board at any time, upon recommendation of the MEC, without the right to a hearing or appeal.

E. ALLIED HEALTH PROFESSIONALS

AHPs shall not be eligible for appointment in, nor appointed to, the Medical Staff. However, AHPs may be assigned to certain departments of the Medical Staff for purposes of participating in medical education and research and for the purposes of reviewing and monitoring the performance of their activities and functions. AHPs shall not be entitled to admit patients and are subject to the general oversight of the Medical Staff.

ARTICLE 7

MEDICAL STAFF OFFICERS - ORGANIZATIONAL STRUCTURE

The following section defines the organizational structure of the Medical Staff including the eligibility requirements of officers, their terms, and duties. Additionally, the process for nomination, selection, vacancy, disqualification and removal of officers is described.

A. OFFICERS, TERMS, AND SUCCESSION

No Member may hold two Medical Staff offices concurrently and no Member may serve simultaneously as an officer and as a department chair.

Officers of the Medical Staff and their terms shall be as follows:

President	2 years
President – Elect	2 years
Secretary	2 years
Treasurer	2 years

Officers begin to serve on the first day of October following their election.

The President-Elect shall upon completion of his/her term in that position immediately succeed to the office of President.

1. ELIGIBILITY REQUIREMENTS

Members on the Active Staff in good standing are eligible to be elected as officers.

2. SELECTION OF OFFICER CANDIDATES

In selecting its officers, the Medical Staff shall consider the responsibilities involved and the interests, respect, cooperation, harmonious interpersonal relationships and skills (including writing and oral communications skills) required to best provide Medical Staff participation in Hospital affairs. Previous committee involvement will also be considered.

a. Nomination

A slate of candidate(s) for President-Elect, Secretary and Treasurer shall be selected by a Nominating Committee composed of the current President, who will serve as Chair, President-Elect, the two most recent past presidents of the Medical Staff and the VPMA who shall serve as an Ex Officio member. The Nominating Committee will present its slate of candidates to the CEO and/or designees.

The current Medical Staff President or CEO may appoint designees that may serve as additional members of the Nominating Committee. The names of such nominees shall be reported to the Medical Staff.

If, before the election, any of the Members nominated for an office shall refuse, be disqualified from, or otherwise be unable to accept nomination, then the Nominating Committee shall reconvene, or in lieu of a meeting, discussion can occur by phone, e-mail or facsimile. The Nominating Committee will nominate Members (in place of such Members who refuse/are disqualified/otherwise unable to accept nomination) and present them to the CEO or his/her designee as set forth in this Section.

b. Election

The President-Elect, Secretary and Treasurer shall be elected prior to the annual Medical staff meeting.

The candidate who receives a majority vote of those Medical Staff Members eligible to vote shall be elected, subject to approval by the Board.

The vote shall be by secret written ballot. Voting by proxy shall not be permitted.

If no candidate for an office receives a majority vote on the first ballot, a run-off election shall be held promptly. The run-off election shall be conducted in the same manner as the first election except the two candidates with the highest number of votes shall be placed on the ballot.

3. VACANCIES

Officers shall maintain the qualifications set forth in Article 7, Section A.4 during their term of office. Failure to do so shall constitute an immediate resignation and shall automatically create a vacancy in the position.

Vacancy in the office of President shall be filled by the President-Elect, who shall fill the unexpired term, then serve his/her own term in office as President.

Vacancy in the offices of President-Elect, Secretary, and Treasurer shall be filled by either a special election held as soon as is reasonably possible in accordance with the terms in Article 7, Section A.2.a and Article 7, Section A.2.b, or such positions may be appointed by the MEC to serve until the next regular election. The MEC will determine the method of filling the vacancy.

4. QUALIFICATION OF OFFICER CANDIDATES/GROUNDS FOR DISQUALIFICATION

Members shall not have adverse recommendations concerning Medical Staff appointments/Privileges, DEA sanctions, documented professional conduct or quality issues for the previous two (2) years, shall not presently serve as a department chair, committee chair or as a Medical Staff officer or corporate officer at another hospital or ambulatory surgery center that competes with the Hospital or have a financial interest (as owner, stockholder, officer, director or employee of an ambulatory surgery center in competition with the Hospital). A Physician's or Specialty Dentist's office practice shall not be considered in competition with the Hospital.

A Member who has served as President is not eligible again for nomination or election to the office of President-Elect until two years have elapsed since he/she held the position of President.

Any officer may resign at any time by giving written notice to the MEC and such resignation shall be effective upon the date of receipt or such later date set forth in such notice.

5. REMOVAL OF OFFICERS

Except as otherwise provided, a Medical Staff officer may be removed by either: (1) Two-thirds (2/3) vote of the MEC where a quorum is present, and a majority vote of the Board where a quorum is present: OR (2) by petition signed by at least one half (1/2) of the Medical Staff members eligible and qualified to vote and a majority of the Board where a quorum is present. Such removal may be based upon any of the following:

- a. failure of the officer to perform the duties required by these Bylaws or the duties as may be assigned by the MEC;
- b. conduct detrimental to the interests of the Hospital;
- c. if the officer is suffering from a physical or mental infirmity that renders the officer incapable of fulfilling the duties of that office, with or without reasonable accommodation; or
- d. other just cause.

In addition, an officer shall automatically relinquish his/her position as soon as he/she no longer maintains Active Staff status in good standing; fails to satisfy any of the qualifications for election to the position at any time during the officer's term; or no longer meets all of the qualifications set forth in Article 7, Section A.4. A vacancy in the position of officer shall be filled in accordance with Article 7, Section A.3.

B. DUTIES OF OFFICERS

1. THE PRESIDENT SHALL:

- a. serve as the Medical Staff's representative in its relationship with others in coordination and cooperation with the VPMA and CEO in matters of mutual concern involving the Hospital;
- b. call, preside at and be responsible for the agenda of all meetings of the full Medical Staff and the MEC;
- c. serve as chair of the MEC and serve at his/her prerogative as Ex-Officio member on all other Medical Staff committees, unless his/her full appointment in a particular committee is required by these Bylaws;
- d. represent the views, opinions, policies, concerns, needs and grievances of the Medical Staff and report on the medical activities of the Medical Staff to the Board, to the CEO and Hospital administration;
- e. serve as an Ex-Officio member of the Board, without vote, and attend the regular meetings of the Board;
- f. act as liaison on medical matters with the CEO and members of Hospital's administration, nursing and other patient care services, the VPMA, and the Board;
- g. be accountable to the Board and the MEC for the quality and efficiency of clinical services and performance within the Hospital;
- h. receive and interpret the policies of the Board to the Medical Staff and report to the Board on the performance and maintenance of quality with respect to the delegated responsibility of the Medical Staff to provide medical care;
- i. be responsible for overseeing the enforcement of the Medical Staff Manuals and implementation of sanctions where indicated;
- j. in collaboration with the VPMA as appropriate, oversee Medical Staff compliance with the procedural safeguards and all rights of individual Members in all stages of the Hospital's credentialing process and in all instances where corrective action has been requested or initiated against a Member;
- k. in collaboration with the VPMA as appropriate, oversee the review and enforcement and compliance with standards of ethical conduct and professional demeanor among the Members of the Medical Staff in their relations with each other, the Board, Hospital administration, other professional and support staff and the community the Hospital serves;
- l. in collaboration with the VPMA, oversee the development, implementation and functioning of the Medical Staff with respect to performance improvement, and assure that all clinical and professional staff are in compliance with regulatory and accrediting requirements;
- m. advise the Board, Hospital administration and the MEC on matters impacting patient care and clinical services; and
- n. perform such other duties as may be assigned to him/her by these Bylaws, the Medical Staff Manuals or the MEC.

2. THE PRESIDENT-ELECT SHALL:

- a. appoint committee chairs and members, in collaboration with the VPMA in accordance with the provisions of these Bylaws, to all standing and special Medical Staff committees, except the MEC or as otherwise set forth in these Bylaws;
- b. assume all the duties and have the authority of the President in the event of the President's temporary inability to perform due to illness or other temporary incapacity, absence from the community or unavailability for any other reason;
- c. serve on the MEC and the Peer Review Committee;
- d. automatically succeed the President should the office of President become vacated for any reason and upon the completion of the current President's term; and
- e. perform such other duties as may be assigned by the President, these Bylaws, the Medical Staff Manuals or the MEC.

3. THE SECRETARY SHALL:

- a. maintain a roster of Members;
- b. cause to be kept accurate and complete minutes of all MEC and Medical Staff meetings;
- c. serve on the MEC;
- d. arrange for giving proper notice of all Medical Staff meetings;
- e. attend to correspondence and notices as appropriate; and
- f. perform such other duties as may be assigned by the President, the Medical Staff Manuals or the MEC.

4. THE TREASURER SHALL:

- a. supervise the collection, account for and safeguard Medical Staff dues, assessments and other funds authorized by the MEC or its designees;
- b. prepare and present financial reports as directed by the MEC;
- c. serve on the MEC; and
- d. perform such other duties as may be assigned by the President, the Medical Staff Manuals or the MEC.

ARTICLE 8

DEPARTMENTS AND SECTIONS

A. ORGANIZATION

The Medical Staff shall be organized into the following departments and sections:

1. Department of Anesthesia
2. Department of Emergency Medicine
3. Department of Family Medicine
4. Department of Medicine
 - a. Behavioral Medicine Section
5. Department of Neurosurgery
6. Department of Obstetrics/Gynecology
7. Department of Orthopedics
8. Department of Pediatrics
9. Department of Radiology
10. Department of Surgery
 - a. Dental Section
 - b. Urology Section
 - c. Ophthalmology Section

B. OBLIGATIONS OF DEPARTMENT AND OR SECTION

Departments and sections shall meet periodically as may be necessary to conduct the business of the department or section at a time set by the chair of the department or section; provided however, at the discretion of the chair or MEC, any such meeting may be cancelled, postponed or scheduled more frequently as needed. The chair shall notify the Medical Staff Office when any such meetings are cancelled or postponed.

C. QUALITY ASSESSMENT AND IMPROVEMENT FUNCTIONS

Each department or section is responsible for the following quality assessment and improvement (peer review) and accountability functions, either individually or together with other committees or components of the Medical Staff and of the Hospital:

1. participate in the peer review process;
2. participate in the credentialing process, including focused and ongoing professional practice evaluation;
3. conduct special studies regarding the input, processes and outcomes of care and specified monitoring activities, including mortality and surgical case reviews, for the purpose of evaluating the clinical work performed;

4. develop minimum requirements for the Clinical Privileges that may be exercised by its Members and others exercising Clinical Privileges within its clinical specialty or subspecialty, review the demonstrated results of Privileges so exercised, and frame recommendations for future Privileges;
5. monitor its Members' performance, on a present and ongoing basis for adherence to Medical Staff, Hospital, department and section policies and procedures, including requirements for alternate coverage and for obtaining consultation; for adherence to sound principles of clinical practice generally; for appropriate surgical and other procedures; for unexpected clinical occurrences; and for patient safety; and
6. establish such committees or other mechanisms as are necessary and desirable to properly perform the quality assessment and improvement (peer review) functions assigned to it, and at such meetings the department or section shall review and evaluate the clinical work of the department or section, consider the findings of ongoing performance improvement, monitor and evaluate activities, and discuss any other matters concerning the department or section.

D. ADMINISTRATIVE FUNCTIONS

Each department or section will assure that its Members contribute their professional views and insights to the formulation of Medical Staff and Hospital policies and procedures and will communicate formulated policies and procedures back to its Members for implementation.

E. COLLEGIAL FUNCTIONS

Departments or sections will serve as peer groups for providing clinical and collegial support among and between peers, for teaching, continuing education, sharing of knowledge, and for providing consultation within the department or section and throughout the Hospital in its specialty area.

F. CREATION AND DISSOLUTION OF DEPARTMENTS/SECTIONS

Subject to the approval of the Board, the MEC may create new departments/sections, eliminate departments/sections, or otherwise reorganize the department/section structure.

G. ASSIGNMENT TO DEPARTMENT/SECTION

Each Member shall be assigned to a clinical department and, if applicable, section, by the VPMA. The department/section chair may request the MEC's review of the decision within thirty (30) days of assignment. Failure to request review shall result in Member's acceptance of his/her department/section assignment. Assignment to a particular department/section does not preclude a Member from seeking and being granted Clinical Privileges typically associated with another department/section. A Member may request that the MEC change his/her department/section assignment to reflect a change in his/her clinical practice. The MEC may, in its sole discretion, assign or reassign a Member to a particular department or section at any time, and Member shall have no right to a hearing or to appeal the decision.

H. FUNCTIONS OF DEPARTMENTS/SECTIONS

The departments/sections shall be organized for the purpose of (i) monitoring and evaluating the quality and appropriateness of the care provided by the Members of the departments/sections, and (ii) providing an organized vehicle for communication between the departments, sections, and the MEC.

I. QUALIFICATIONS OF DEPARTMENT/SECTION CHAIRS

Each department/section chair shall:

1. be an Active Staff Member in good standing;
2. be Board Certified (not required for section chairs);
3. satisfy the qualifications for Medical Staff officers as enumerated in Article 7, Section A.4; and
4. be privileged in at least one of the clinical areas covered by the department/section.

J. APPOINTMENT, RESIGNATION, VACANCY AND REMOVAL OF DEPARTMENT/SECTION CHAIRS

1. NOMINATION

The process for nominating department and section chairs shall be accomplished through nominating committees of the department or section. Each nominating committee shall be comprised of the two (2) past chairs of the applicable department or section, the current chairs and the VPMA and Medical Staff President who shall serve as Ex Officio members. Each nominating committee shall nominate no greater than two (2) qualified candidates for the office of department chair or the office of section chair, as applicable.

For those departments comprised of Members whose groups have an exclusive contract with the Hospital for a contracted service, (e.g. Anesthesia, Emergency Medicine and Radiology), these departments will provide the Medical Staff Office with the names of their department chair selection. These names are subject to administrative and MEC approval and Board confirmation.

2. ELECTION

Except as provided in Article 8, Section J.1, the chair of the departments and the chair of the sections are chosen by election by majority vote cast by secret ballot by those Members of the department or section who are eligible and qualified to vote for department and section chairs. The ballot shall provide for write-in candidates. If no candidate for the office of chair receives a majority vote on the first ballot, a run-off election will be held promptly. The run-off election shall be conducted in the same manner as the first election except the two candidates with the highest number of votes shall be placed on the ballot. The candidate who receives a majority vote of those Medical Staff Members within the department or section eligible to vote shall be elected, subject to approval by the Board.

Department/section chairs shall serve a term of two (2) years. The department and section chairs are eligible for re-election.

Chairs of the departments of Anesthesia, Pediatrics, Surgery and chairs of the sections of Dental, Ophthalmology and Urology shall be elected prior to the beginning of odd fiscal years.

Chairs of the department of Emergency Medicine, Family Medicine, Medicine, Neurosurgery, OB/GYN, Orthopedics, Radiology and chairs of the section of Behavioral Medicine shall be elected prior to the beginning of the even fiscal years.

3. RESIGNATION

A department and or section chair may resign at any time by giving written notice to the MEC and such resignation shall be effective upon the date of receipt or such later date set forth in such notice.

4. VACANCY

Vacancies shall be filled by either a special election to be performed in accordance with the terms of Article 8, Section J.1 and Article 8, Section J.2 as soon as is reasonably possible or may be appointed by the MEC to serve until the next regular election. The MEC will determine the method of filling the vacancy.

5. REMOVAL

Except as otherwise provided, a department/section chair may be removed by either: (1) Two-thirds (2/3) vote of the MEC where a quorum is present, and a majority vote of the Board where a quorum is present: OR (2) by petition signed by at least one half (1/2) of the Medical Staff members eligible and qualified to vote and a majority vote of Board where a quorum is present. Such removal may be based upon any of the following:

- a. failure of the department/section chair to perform the duties required by these Bylaws or as may be assigned by the MEC;
- b. conduct detrimental to the interests of the Hospital;
- c. if the department/section chair is suffering from a physical or mental infirmity that renders the department/section chair incapable of fulfilling the duties of that position, with or without reasonable accommodation; or
- d. other just cause.

In addition, a department/section chair shall automatically relinquish his/her position as soon as he/she no longer maintains Active Staff status in good standing; fails to satisfy any of the qualifications for election to the position at any time during the department/section chairs term; or if he/she no longer meets all of the qualifications set forth in Article 8, Section I. A vacancy in the position of department/section chair shall be filled in accordance with Article 8, Section J.4.

K. ROLES AND RESPONSIBILITIES OF DEPARTMENT/SECTION CHAIRS

Each department/section chair is accountable for the following:

1. all clinically related activities of the department/section;
2. all administratively related activities of the department/section, unless otherwise provided for by the Hospital;
3. continued monitoring of the professional performance of all individuals in the department/section who have delineated Clinical Privileges;
4. recommending to the Medical Staff criteria for Clinical Privileges that are relevant to the care provided in the department/section;
5. evaluating requests for Clinical Privileges for each member of the department/section;
6. assessing and recommending to the VPMA or CEO or his/her designee(s) off-site sources for needed patient care, treatment and services not provided by the department/section or the Hospital;
7. the integration of the department/section into the primary functions of the Hospital;
8. the coordination and integration of interdepartmental and intradepartmental services;
9. the development and implementation of policies and procedures that guide and support the provision of care, treatment, and services;
10. recommendations for a sufficient number of qualified and competent persons to provide care, treatment and service;
11. determination of the qualifications and competence of AHPs who provide patient care, treatment and services within the department/section;
12. continuous assessment and improvement of the quality of care and services provided;
13. maintenance of quality monitoring programs, as appropriate;
14. the orientation and continuing education of all persons in the department/section;
15. recommendations for space and other resources needed by the department/section; and
16. performing all functions authorized in the Medical Staff Manuals and Hospital policies including collegial intervention.

ARTICLE 9

COMMITTEES AND MEETINGS

A. TYPES OF MEETINGS

1. MEC
2. General (Annual) and Special Medical Staff Meetings
3. Department/Section/Committee Meetings
4. Standing and Permanent Medical Staff Committee Meetings – See Appendix A for identification of such committees.

B. PROVISIONS COMMON TO ALL MEETINGS

1. ATTENDANCE REQUIREMENTS

Each Member is expected to attend all meetings of the Medical Staff as well as meetings of the applicable department, section and Medical Staff committees to which the Member has been appointed. The MEC has the authority to require attendance at any meeting it determines to be mandatory.

In general, any Member of the Medical Staff may attend MEC and/or department/section/committee meetings as a guest. However, it is within the discretion of the MEC or department/section/committee to excuse a Member from all or part of the meeting if it is determined that such removal is necessary to protect confidentiality (e.g. peer review) or is otherwise in the best interest of the MEC or department/section/committee.

2. VOTING

Any voting Member who, by virtue of his or her position, attends a meeting in more than one capacity shall be entitled to only one vote. There shall be no proxy voting.

3. NOTICE OF MEETINGS

Notice of all committee meetings shall state the date, time and place of the meeting. Members will be notified in advance of meetings. Notice may be given in person or by mail, facsimile, electronic mail or other appropriate means.

C. MEDICAL EXECUTIVE COMMITTEE

1. PURPOSE OF MEC

The MEC is empowered to act for the Medical Staff and to coordinate all activities and policies of the Medical Staff and its departments, sections and committees, except for matters requiring full Medical Staff approval.

2. SIZE AND COMPOSITION OF MEC

The voting MEC members shall consist of the officers of the Medical Staff and the chair of each department. In addition, the following shall be Ex Officio Members:

- a. VPMA
- b. Chair, Family Medicine Residency
- c. CEO or his/her designee(s)
- d. Senior Vice President of Hospital Services
- e. Chief Nursing Executive
- f. Any other Member the MEC approves

3. FUNCTION/DUTIES OF MEC

The MEC shall:

- a. serve as the decision-making body of the Medical Staff in accordance with these Bylaws and to provide oversight for all Medical Staff functions;
- b. be empowered to act on behalf of the Medical Staff between meetings of the Medical Staff;
- c. be accountable to the Board and to the Medical Staff for the overall quality and efficiency of professional patient care, treatment and services provided in the Hospital by Members with Clinical Privileges, AHPs, and coordinate the participation of the Medical Staff in organizational performance improvement activities;
- d. make recommendations to the Board on:
 - (i) all matters relating to appointments, reappointments, staff category and departmental assignments and Clinical Privileges;
 - (ii) the Medical Staff's structure;
 - (iii) the process used to review credentials and delineate Privileges;
 - (iv) the delineation of Privileges for each Member privileged through the Medical Staff process; and
 - (v) review and act on reports of Medical Staff committees, departments and other assigned activity groups.
- e. take reasonable steps to encourage professionally ethical conduct and competent clinical performance on the part of Medical Staff Members, including collegial and educational efforts and investigations when warranted;

- f. make recommendations to the CEO and Board on administrative and Hospital management affairs, including patient care needs such as space, staff, and equipment;
- g. keep the Medical Staff up to date concerning licensure and accreditation status of the Hospital;
- h. evaluate information received from the Graduate Medical Education Committee regarding safety and quality of patient care, treatment and services provided by residents;
- i. resolve inter-departmental conflicts when necessary and possible; and
- j. evaluate the Medical Staff performance improvement activities and, if a problem is identified, take action that will be documented in the MEC minutes.

4. REMOVAL FROM MEC

- a. Any Member whose position as an officer or department chair is terminated for any reason in accordance with these Bylaws shall be automatically removed from his/her position on the MEC. A member of the MEC shall also be automatically removed from the MEC if he/she fails to maintain Active Staff status in good standing, or if he/she fails to satisfy any of the qualifications for election to the position at any time during the term.
- b. Any Member of the MEC may also be removed from the MEC for any of the following reasons:
 - a. failure of the department chair or officer to perform the duties required by these Bylaws or as may be assigned by MEC;
 - b. conduct detrimental to the interests of the Hospital;
 - c. if the department chair or officer is suffering from a physical or mental infirmity that renders the department chair or officer incapable of fulfilling the duties of that position, with or without reasonable accommodation; or
 - d. other just cause.

A Member of the MEC may be removed for any of the reasons in subsection b by either: (1) Two-thirds (2/3) vote of the MEC where a quorum is present, and a majority vote of the Board where a quorum is present: OR (2) by petition signed by at least one half (1/2) of the Medical Staff members eligible and qualified to vote and a majority vote of the Board where a quorum is present.

5. MEC MEETING

The MEC shall meet monthly. However, any such meeting may be cancelled, postponed or scheduled more frequently as needed. The chair shall notify the Medical Staff Office of such.

6. NOTICE OF MEC MEETINGS

Notice of the MEC meetings shall state the date, time and place of the meeting. Members will be notified in advance of meetings. Notice may be given in person or by mail, facsimile, electronic mail or other appropriate means.

7. MEC AGENDA

The agenda shall be set by the chair (or designee) thereof and the agenda shall be made available to all members of the MEC and, upon request, to any Member of the Medical Staff.

8. MEC MINUTES

Minutes of each meeting shall be prepared and maintained as a permanent record, including attendance and of its findings, proceedings and actions taken, and shall be signed by the chair (or designee).

9. MEC QUORUM

The presence of a majority of members of the MEC eligible to vote shall constitute a quorum.

Once a quorum is established, the business of the meeting may continue and all actions taken shall be binding even though less than a quorum exists at a later time in the meeting. If it is anticipated that a quorum will not be present at an MEC meeting or a quorum is not present at the meeting, the Medical Staff President or his/her designee may poll an absent MEC Member(s) either before, during or after the meeting via e-mail, telephone or in person and such vote of the absent member(s) shall be counted to constitute a quorum on the matter voted upon.

D. GENERAL AND SPECIAL MEDICAL STAFF MEETINGS

The Medical Staff shall meet annually during the first quarter of the Corporation's fiscal year. Special meetings of the Medical Staff may be called at any time by:

1. The Medical Staff President;
2. A majority of the MEC members in attendance where a quorum is present;
3. A petition signed by not fewer than one-third (1/3) of the Active and Provisional Active Staff which is submitted to the MEC; or
4. At the written request of the Board.

1. NOTICE OF MEETING

The person or body calling or requesting the meeting shall notify the Medical Staff office in writing of the purpose of the meeting. At least fifteen (15) days prior to the meeting, the Medical Staff Office shall send written notice to the Members specifying the place, date, time and purpose of the meeting. The meeting shall be scheduled by the Medical Staff Office within sixty (60) days of receipt of such request, but the meeting does not have to occur within this sixty (60) day period.

A copy of the document(s) to be acted upon at the meeting shall be mailed, emailed or faxed to each Member at least seven (7) days before the meeting.

No business shall be transacted at any general or special meeting except that stated in the notice.

2. QUORUM

The Active and Provisional Active Members in attendance shall constitute a quorum for any regular or special meeting of the Medical Staff.

3. VOTE BY BALLOT OR IN PERSON

The MEC shall determine whether an issue will be presented to the Medical Staff via ballot in lieu of an in-person meeting or via in-person meeting.

4. VOTE BY BALLOT

In the event that it is necessary for the Medical Staff to vote on an issue, a ballot may be sent by the Medical Staff President or his/her designee by mail, e-mail or facsimile with a copy of the proposed documents to be acted upon to the Active and Provisional Active Members. Ballots must be returned to the Medical Staff Office within twenty (20) days of the date of mailing/emailing/faxing the ballot. An issue will pass if a majority of ballots returned by the deadline established are in favor of the issue. The MEC shall determine if the ballots will be secret. A vote on the Medical Staff Bylaws is governed by the provisions in Article 10, Section B.

5. VOTE IN PERSON

An issue will pass if a majority of those Active and Provisional Active Members in attendance vote in favor of the issue.

6. MEDICAL STAFF MEETING MINUTES

Minutes of each meeting shall be prepared and maintained as a permanent record, including attendance and of the Medical Staff's findings, proceedings and actions taken, and shall be signed by the Medical Staff President (or designee).

7. AGENDA

The agenda at any regular or special Medical Staff meeting shall be set by the Medical Staff President and the agenda shall be made available to the Active and Provisional Active Members.

E. DEPARTMENT/SECTION/COMMITTEE MEETINGS

All committees shall periodically meet as necessary to conduct the business of the committee at a time set by the chair (or designee) of the committee.

1. CHAIRS

All committee chairs will be appointed by the current President-Elect in collaboration with the VPMA. A chair may serve for an unlimited number of additional terms.

2. MEMBERS

Except as otherwise provided for in these Bylaws, members of each committee shall be appointed by the President-Elect of the Medical Staff in collaboration with the VPMA. There shall be no limitation in the number of terms they may serve.

Members of any committee, unless otherwise specified in these Bylaws, may include representatives from Hospital administration, nursing, health information management, or other Hospital departments or services as are appropriate.

Non-Medical Staff Members of a committee shall serve without a vote unless otherwise specified at the time of selection or appointment to a committee as set forth in these Bylaws.

A Member of a committee may be removed by the MEC if i) a Member of a committee ceases to be a Member in good standing on the Medical Staff; ii) the Member's employment, if applicable, the Member's contractual relationship with the Hospital or the contractual relationship between the Hospital and the Member's group was the basis for appointment to the committee and such relationship terminates; iii) the Member suffers a loss or significant limitation of Clinical Privileges; iv) the Member fails to satisfy any attendance requirements set by the committee; or v) any other good cause exists.

3. AGENDA

The agenda at any regular or special department/section/committee meeting shall be set by the chair (or designee) and the agenda shall be made available to all members of such department/section/committee.

4. MINUTES

Minutes of each department/section/committee shall maintain a permanent record of attendance and of its findings, proceedings and actions taken, and a copy shall be submitted to the MEC, if applicable.

5. QUORUM

The Active and Provisional Active Members of the committee in attendance shall constitute a quorum for any regular or special meeting (but in no event less than two (2) members).

Once a quorum is established, the business of the meeting may continue and all actions taken shall be binding even though less than a quorum exists at a later time in the meeting (but in no event less than two (2) members).

6. VOTE BY BALLOT OR IN PERSON

The department/section/committee shall determine by a majority vote where a quorum is present whether an issue will be presented to the department/section/committee via ballot or in-person meeting.

7. VOTE BY BALLOT

In the event that it is necessary for the department/section/committee members to vote on an issue, a ballot may be sent by the department/section committee chair or his/her designee by mail, e-mail or facsimile with a copy of the proposed documents to the members. Members shall have at least fifteen (15) days to return their ballots. An issue

will pass if a majority of ballots returned by the deadline established are in favor of the issue. The department/section/committee chair shall determine if the ballots will be secret.

8. VOTE IN PERSON

An issue will pass if a majority of those Active and Provisional Active Members of the department/section/committee in attendance at the department/section/committee meeting where a quorum is present vote in favor of the issue.

F. STANDING COMMITTEES

The standing or permanent committees shall be described in Appendix A attached to these Bylaws.

G. CREATION – DISSOLUTION – MODIFICATION

The MEC may, without amendment of these Bylaws, restructure existing committees or establish additional committees to perform one or more Medical Staff functions and may, upon receipt of Board approval, dissolve a committee as needed to better accomplish Medical Staff functions. Appendix A shall be updated (without Medical Staff approval) after action by the MEC or Board, as applicable.

ARTICLE 10

MEDICAL STAFF MANUALS AND BYLAWS REVIEW, REVISION, ADOPTION AND AMENDMENT

A. MEDICAL STAFF RESPONSIBILITY

The Medical Staff shall be responsible for recommending to the Board these Bylaws and amendments thereto in accordance with the terms of these Bylaws, which shall be effective when approved by the Board. Such responsibility shall be exercised in good faith and in a reasonable, responsible and timely manner.

B. APPROVAL OF OR AMENDMENT TO BYLAWS

1. The MEC shall review proposed new or amended Bylaws prior to submission to the Medical Staff. The Medical Staff shall thereafter vote on the proposed new or amended Bylaws in any of the following methods, as determined by the MEC:
 - a. by mailed/mailed/faxed ballots to all eligible voters and returned by mail or otherwise to the Medical Staff Office within twenty (20) days of the date of mailing/emailing/faxing; an issue will pass if a majority of ballots returned are in favor of the issue, or
 - b. at the next regular meeting of the Medical Staff, or at a special meeting called for such purpose, by a majority vote of eligible voters present.
2. In the event that any proposed amendments or additions are to be voted upon at a meeting of the Medical Staff as provided in Article 10, Section B(1)(b), notice of such proposed amendment(s) or addition(s) shall first be provided to the Medical Staff by posting such proposed action in the Medical Staff lounges, if any, by facsimile, electronic mail and/or by any other means reasonably calculated to reach the Medical Staff as determined by the MEC at least thirty (30) days prior to the meeting of the Medical Staff at which the action thereon is to be taken.
3. During a general or special Medical Staff meeting, an Active or Provisional Active Member may propose to modify the Bylaws or amendments presented, by motion duly made and seconded, notwithstanding the notice provisions in this Article 10. However, in the event that either the VPMA or Medical Staff President (or his/her designee) determine that such proposed amendment is a substantive change and not merely technical, grammatical, correction or an otherwise minor modification, either may require that prior to any motion to approve such amendment being considered by the Medical Staff notice of such proposed amendment shall be given to the Medical Staff as provided in Article 10, Section B(2) and the amendment shall be considered at a subsequent meeting or the amendment shall be presented for approval by ballot as provided in Article 10, Section B(1)(a).
4. The MEC is hereby delegated the power on behalf of the Medical Staff to adopt such amendments to these Bylaws without prior Medical Staff approval when the MEC determines adoption is needed to comply with law or regulation and the time for the Medical Staff amendment process otherwise set forth in these Bylaws, would not reasonably allow for Medical Staff approval as a whole; provided, however, that following approval of such

amendment by the MEC the Medical Staff shall be immediately notified of such approved amendment in the same manner described in Article 10, Section B(2). The Medical Staff shall have the right to comment on such amendment. In the event no objection to such amendment, addition or repealed provision is received by the MEC within thirty (30) days of notification of the approval of such amendment, addition or repealed provision by at least ten percent (10%) of the voting members of the Active Medical Staff (as evidenced by a petition signed by such Members) such amendment, addition or repeal shall stand and be effective, subject to Board approval. If such an objection from at least ten percent (10%) of the voting members of the Active Medical Staff is received within such thirty (30) days, the matter shall be submitted to the Medical Staff for its approval (or rejection) at the next general Medical Staff meeting or at a special meeting called for such purpose or such matter may be submitted to the Medical Staff for vote by mail or other method as determined by the MEC. Such amendments shall be effective upon approval by the Board.

5. Notwithstanding the provisions of Article 10, Section B(1), amendments to these Bylaws may also be approved by the Medical Staff as a whole at any regular meeting or special meeting called for that purpose by the submission of such proposed amendment by a petition signed by at least ten percent(10%) of the voting members of the Active Medical Staff setting forth such proposed amendment, provided that notice of such amendments has been given to the Medical Staff Office and to the Medical Staff prior to the meeting of the Medical Staff in the manner described Article 10, Section B(2).
6. Approval of these Bylaws or amendments thereto are effective only when approved by the Board.
7. Notwithstanding the above amendment process, typographical, grammatical, numbering, spacing and other non-substantive corrections to these Bylaws may be made by the Medical Staff Office without approval of the Medical Staff.

C. BOARD INITIATIVE

In the event that the Medical Staff shall fail to approve such amendments to the Bylaws and/or the MEC fails to approve such amendments to the Credentialing Procedures Manual, Rules and Regulations or any other related Medical Staff documents which are required to comply with changes in Joint Commission standards, state or federal law (including applicable agency regulations or judicial decisions or interpretations), or regulatory direction, after notice from the Board and a reasonable period of time for response, the Board, upon affirmative vote of a majority of the members of the Board, may exercise its responsibility and authority to approve such amendments that are reasonably required to reduce potential liability, prevent loss of accreditation, licensure, fines or penalties to the Hospital or Members of the Medical Staff. In the event of such action, notice shall be given promptly after such action to the MEC and the Members of the Medical Staff of such amendments, who shall have the opportunity to comment thereon. In the event objection to such amendments is received by the Chief Executive Officer or President of the Board from the MEC or at least ten percent (10%) of the voting members of the Medical Staff (as evidenced by a petition signed by such Members) within thirty (30) days after notice is given of such Board action, the matter shall be subject to the dispute resolution process described in Article 13.

D. REVIEW OF MEDICAL STAFF MANUALS

The Medical Staff Manuals shall be reviewed at least every three (3) years and revised as necessary.

E. CREDENTIALING PROCEDURES MANUAL AND RULES AND REGULATIONS

1. In addition to these Bylaws, there shall be a Credentialing Procedures Manual and Rules and Regulations (previously defined as the “Medical Staff Manuals”). These Medical Staff Manuals shall be applicable to all Applicants and Members of the Medical Staff and other individuals who have been granted appointment and/or Clinical Privileges or a scope of practice.
2. The Credentialing Procedures Manual and the Rules and Regulations may be amended by a majority vote of the members of the MEC present and voting at any meeting of the MEC where a quorum exists, and such authority is hereby delegated to the MEC. Agreement to abide by the Bylaws includes an agreement to abide by the Credentialing Procedures Manual and Rules and Regulations. In the event of such amendment, notice of such amendment shall be given to all Members of the Medical Staff and the same procedure in the event of objection thereto set forth in Article 10, Section B(4) shall be followed.
3. Amendments to the Medical Staff Manuals may also be amended in the same manner described in Article 10, Section B(5).
4. No amendment to the Medical Staff Manuals shall be effective until it has been approved by the Board.

F. PROCEDURE WHERE HOSPITAL IS CONSIDERING NEW EXCLUSIVE CONTRACT

For purposes of this Section, “new exclusive contract” shall mean a proposed exclusive contract between Hospital and a Physician or group of Physicians or a Specialty Dentist or group of Specialty Dentists to 1) provide exclusive professional services in a specialty or subspecialty other than those specialties or subspecialties listed in the Credentialing Procedures Manual under the Section titled “Exclusive Contractual Professional Services” or to 2) provide professional services that are not covered by an existing exclusive contract.

Before the Hospital and the Board may approve a new exclusive contract with a Physician or group of Physicians or Specialty Dentist or group of Specialty Dentists, the following shall occur:

1. Joint Committee of the Board and Medical Staff

A joint committee of the Board and Medical Staff (hereinafter referred to in this section as “Committee”) shall be formed to consider such contract. The Committee shall consist of equal numbers of Board Members (appointed by the Chairman of the Board) and Active Medical Staff Members (appointed by the MEC). One of the Committee’s members shall be designated as chair. The Committee shall meet within thirty (30) days of appointment to discuss the proposed new exclusive contract and to provide Members an opportunity to express support or concerns for the new exclusive contract. The Committee may meet more than once and may establish its own procedures for the meeting, which may be amended

from time to time. The Committee shall submit its recommendation in writing to the Board no later than thirty (30) days after it has concluded its meeting(s). Notwithstanding the above, the Committee's recommendation must be made to the Board no later than one hundred twenty (120) days after the date on which the Committee first met.

2. Final Board Action

The Board shall meet within thirty (30) days of receipt of the Committee's written recommendation to consider the recommendation. The Board may ask for additional or clarifying information from the Committee or the Members who presented information to the Committee. The Board shall render its final decision within thirty (30) days of its completed review of the matter, and the decision shall be immediately effective and final.

If the Board approves a new exclusive contract, the Credentialing Procedures Manual shall address the effect such contract shall have on a Member's existing privileges and/or appointment.

ARTICLE 11

CORRECTIVE ACTION

A. INVESTIGATIONS

1. PROBLEM IDENTIFICATION

Patterns or incidents that adversely affect, or could adversely affect patients, the Medical Staff, the Hospital, or its employees or others, are addressed by department chairs, and/or the MEC and Board in a timely manner. Problem identification relating to a Member's clinical judgment or skills, compliance with Hospital and/or Medical Staff rules or these Bylaws, physical or mental status, efficient practice, or ethical conduct, may be obtained through information developed routinely in response to peer review, performance improvement activities, or by a complaint from a Medical Staff Member, patient, Hospital or others.

2. CRITERIA FOR INITIATION

Whenever, on the basis of information and belief, any Member of the Medical Staff, any AHP, employee of the Hospital, the VPMA, the CEO or the Chairman of the Board has cause to question the actions of a Medical Staff Member involving any of the grounds described in Article 11, Section A.2.a., below, he/she shall submit an oral (to be followed up in writing) or written statement or report to the VPMA or his/her designee identifying the Member involved and describing the specific incident, activity or conduct which gave rise to the statement or report. Further, if the matter involves a potential violation of the CoxHealth Compliance Plan or Code of Conduct, the Vice President of Corporate Integrity of the Hospital shall be notified, and he/she may conduct an investigation independent of or in connection with any investigation under this Article.

- a. The following shall be grounds for initiating an oral or written statement or report regarding the conduct or activity of a Member and is not intended to be an exclusive list:
 - (i) questions regarding clinical competence, the care or treatment of a patient(s) or management of a case;
 - (ii) the known or suspected violation by any Member of applicable ethical, licensing or drug registration standards, the Medical Staff Manuals, or policies of the Medical Staff, Hospital or the Board, including, but not limited to the Hospital's quality management (for example, patient safety, accreditation, peer review, quality assurance/quality improvement, etc.), risk management, and utilization review programs and the CoxHealth Compliance Plan or Code of Conduct or involves conduct which is prohibited under any local, state or federal law or regulation;
 - (iii) behavior or conduct on the part of any Member that is considered lower than the standards of the Hospital or disruptive to the orderly operation of the Hospital or the Medical Staff, including the inability of the Member to work harmoniously with other Members, AHPs, nurses and staff or Hospital administration;

- (iv) the existence of any significant misstatements in or omissions from the Member's application for appointment or reappointment to the Medical Staff or matters submitted in connection therewith;
- (v) questions involving any disciplinary action taken or initiated against a Member by another hospital or entity;
- (vi) a conviction, charge, indictment or investigation by federal or state authorities concerning suspected Medicare, Medicaid or other government sponsored healthcare plan or insurance fraud, including any violation of federal or state anti-kickback laws or false claims acts;
- (vii) a conviction or indictment for, or investigation into, suspected drug law violations;
- (viii) litigation or arbitration proceedings, including testimony (deposition, hearing or trial) given by a Member as an expert witness or otherwise, which may call into question a Member's qualifications, competency, medical or professional judgment, conduct or ability to practice;
- (ix) questions involving the Applicant's or Member's ability to perform the essential functions of his/her Clinical Privileges, with or without accommodation, without posing a threat or danger to the health or safety of himself/herself, other providers, patients or others;
- (x) questions involving the use of drugs or alcohol in violation of Hospital policy;
- (xi) falsification or suspected falsification of medical records or inappropriate information documented in a patient's medical record that is not related to the care of the patient; or
- (xii) questions involving the revocation, termination, suspension or restriction of licensing federal or state drug registration, professional liability insurance, medical staff appointment or Clinical Privileges at another hospital or continuing medical education requirements.

3. PRELIMINARY REVIEW BY THE VPMA AND/OR PEER REVIEW COMMITTEE

Upon receipt of a statement or report pursuant to Article 11, Section A.2.a, or upon receipt of a complaint or other notice from a patient or family member of a patient concerning any matter described in Article 11, Section A.2.a, the VPMA, his/her designee or the Peer Review Committee shall notify the applicable department chair and provide him/her with a copy of the complaint. If the VPMA, his/her designee or Peer Review Committee deems appropriate, he/she/it shall also notify the Medical Staff President and the CEO of the complaint. The VPMA, his/her designee or Peer Review Committee shall keep the department chair, Medical Staff President and/or CEO, as applicable, fully informed of all action taken in connection therewith.

In the event the Member involved is also an employee of the Hospital, the VPMA, his/her designee, or Peer Review Committee shall consult with and coordinate, as applicable, with the Human Resources Department of the Hospital.

The VPMA, his/her designee or Peer Review Committee shall preliminarily review the matter and shall interview, as the VPMA, his/her designee or Peer Review Committee

deems necessary or appropriate, appropriate Members of the Medical Staff, AHPs, Hospital personnel and, if the VPMA, his/her designee or Peer Review Committee deems appropriate, the Member being investigated. In the event the complaint involves a potential violation of CoxHealth's Compliance Plan or Code of Conduct, the VPMA, his/her designee or Peer Review Committee shall notify the Hospital's Vice President of Corporate Integrity or his/her designee, if not previously notified, and coordinate, as appropriate, the investigation of the VPMA, his/her designee or Peer Review Committee with the Vice President of Corporate Integrity or his/her designee.

The VPMA, his/her designee or Peer Review Committee may utilize the expertise of one or more Members of the Medical Staff or others (including the Hospital's counsel) to advise him/her/it as to specific patient care issues or other matters that are deemed helpful to the review and initial evaluation. In the event the VPMA, his/her designee or Peer Review Committee determines that he/she/it is unable to resolve the matter, or is unable to determine that there is no substance to the complaint or basis for either the allegation or for taking action against such Member, after consultation with the department chair, Medical Staff President and CEO, except as hereafter provided, the VPMA, his/her designee or Peer Review Committee, shall promptly refer the matter to the MEC and shall notify the Member that the matter is under investigation and has been referred to the MEC or designated committee as applicable. In the event the VPMA, his/her designee or Peer Review Committee is able to resolve the matter or determines that there is no basis for action against the Member, the VPMA, his/her designee or Peer Review Committee may notify the department chair, Medical Staff President and CEO of his/her findings, conclusions and action taken, in which case the matter shall not be referred to the MEC.

4. INVESTIGATION BY THE MEC

The MEC (its ad hoc committee or Peer Review Committee) shall formally investigate a complaint:

- a. upon receipt of a report from the VPMA, his/her designee or Peer Review Committee that he/she/it has been unable to resolve the complaint;
- b. upon receipt of a report from the VPMA, his/her designee or Peer Review Committee that he/she has been unable to determine that there is no basis for action against the Member and has determined that an investigation should be undertaken; or
- c. if the Medical Staff President or CEO disagrees with the conclusion of the VPMA, his/her designee or Peer Review Committee that no basis existed either for the allegation or for taking action against the Member.

The VPMA, his/her designee or Peer Review Committee shall provide to the MEC copies of the complaint and his/her/its investigation.

The MEC may investigate the matter itself, refer the matter to outside peer review or may appoint an ad hoc committee that is comprised of no fewer than three (3) Physicians who may (but need not be) Members of the Medical Staff and who are not affiliated with or in direct economic competition with the Member in question. A Member who is in

direct economic competition with the Member in question may sit on the committee where that Member's expertise is needed; however, that Member shall not participate in the committee's deliberation, attempt to influence its decision, or have a vote in the matter. The committee shall not include relatives of the Member being investigated. Committee appointees will be promptly notified. If practical, the VPMA shall direct and coordinate the investigation unless the VPMA is perceived to be biased against the Member or is otherwise unavailable, in which event the VPMA's designee shall direct the investigation.

a. Investigative Procedures of the MEC, Ad Hoc Committee and/or Peer Review Committee

- (i) Notwithstanding the below, the MEC reserves the right to conduct any investigation on its own without referring the matter to an ad hoc committee or may utilize the Peer Review Committee to conduct the investigation. If the MEC conducts the investigation or utilizes the Peer Review Committee, the applicable committee shall follow the processes and have the same powers set forth below for an ad hoc committee's investigation.
- (ii) If appointed, the ad hoc committee shall meet as soon as reasonably practicable, but not later than thirty (30) days after appointment. After evaluating the request for an investigation, if the ad hoc committee determines that:
 - (1) there is no basis for either the allegation or taking action against the Member, the committee may, at its discretion, make a recommendation that no action is justified. The committee may make this recommendation with or without a personal interview with the Member being investigated; or
 - (2) the request for an investigation contained sufficient information to warrant a full investigation, or that it cannot determine that there is no basis for the request, the committee shall immediately investigate the matter. If the committee determines after initial review that investigation is warranted, the chair of the committee shall advise the Member that the matter has been referred to the committee for investigation.

The Member under investigation shall have an opportunity to meet with the ad hoc committee and/or the MEC before it makes a report of its investigation and conclusions to the MEC. At this meeting (but not, as a matter of right, in advance of it) the Member shall be informed of the general nature of the evidence supporting the matter being investigated and shall be invited to discuss, explain, or refute such evidence. This interview shall be administrative in nature and shall not constitute a hearing, and none of the procedural rules provided in these Bylaws with respect to hearings shall apply. Since such meeting is not a hearing in accordance with the hearing procedures of these Bylaws, the Member under

investigation shall not be permitted to have an attorney or other representative present. A summary of such interview, if held, shall be made by the committee and shall be included with its report to the MEC.

The committee may review charts or other records, all documents it considers relevant, interview witnesses or review any other evidence or information available within a time period reasonable under the circumstances. The committee shall also have available to it the full resources of the Medical Staff and the Hospital, as well as the authority to use outside consultants, if needed. If the committee believes that the physical or mental condition or abilities of the Member are in issue, such committee may also require a physical and/or mental examination of the Member being investigated by a physician(s) satisfactory to such body. The committee may also require that the Member submit to a blood and/or urine test. The committee shall be provided a copy of any report requested that addresses the ability of the Member.

If the matter under investigation involves a violation of the CoxHealth Compliance Plan or Code of Conduct, the committee shall work with and coordinate the investigation with the Vice President of Corporate Integrity in any investigation conducted by the Vice President of Corporate Integrity or his/her designee.

Contemporaneous evidence of the ongoing investigation, meeting minutes (if any), and/or letters to the Member or others will be maintained in the Member's confidential peer review file. A written report of the ad hoc committee's findings, conclusions, and recommendations will be forwarded to the MEC as soon as practical.

Despite the status of any investigation, at all times the MEC shall retain authority and discretion to take whatever action warranted by the circumstances, including precautionary suspension, termination of the investigative process or other action.

The MEC shall meet as quickly as practical after receipt of the ad hoc committee's report (but in no event later than thirty (30) days) to consider the findings and recommendations of the committee and determine what, if any, remedy is appropriate or if further investigation is warranted.

A general or routine review of cases of a particular Member does not constitute an investigation under this Section.

5. REQUESTS TO MEET, PROVIDE INFORMATION AND SUBMIT TO EXAMINATION

Whenever suspected deviation from standard clinical practice or professional conduct is identified, the MEC or its ad hoc committee, VPMA and/or Medical Staff President may make a mandatory request that the Member:

- a. meet to consider the matter at hand;
- b. submit to a physical or psychological examination (or similar examination);
- c. submit to a urine or blood test (or similar test);
- d. provide information or documentation requested; and/or
- e. comply with any other reasonable request.

If a meeting is requested, the Member will be given notice of the meeting at least forty-eight (48) hours prior to the meeting, will be provided with the date, time, location of the meeting, and will be provided with a statement of the issue involved. The Member shall have no right to counsel or other representation at the meeting as the meeting does not constitute hearing or appeal. For all other requests, the Member will be given reasonable notice of a timeframe within which the Member's compliance is expected. If the Member fails or refuses to comply with a request outlined above after two notices, the Member will be placed on a leave of absence for a period of thirty (30) days. If Member fails to attend the requested meeting or to otherwise comply with the request within thirty (30) days of being placed on leave, the Member shall be deemed to have voluntarily resigned his/her Medical Staff appointment, and Member shall have no right to hearing or appeal. Member shall not be permitted to reapply for Medical Staff appointment for one (1) year, unless the VPMA and the Medical Staff President agree. If the Member attends the requested meeting or otherwise complies with the request within the thirty (30)-day timeframe, he/she shall be removed from leave of absence and his/her appointment shall be reinstated as it was prior to the leave of absence.

6. PRECAUTIONARY (SUMMARY) SUSPENSION OF PRIVILEGES DURING INVESTIGATION/REVIEW

- a. If at any time during the investigation, the ad hoc committee believes that in the interest of patient safety or care the orderly operation of the Hospital or otherwise for the protection of the Hospital or patient care, the Clinical Privileges of the Member under investigation should be suspended or restricted in whole or in part, the committee shall notify the VPMA, the CEO or the Medical Staff President. The VPMA, CEO or the Medical Staff President may, after first notifying the others (if not otherwise notified), based upon the report of such committee, immediately suspend or restrict all or any part of the Member's Clinical Privileges as provided in Article 11, Section B, or refer the matter to the MEC for evaluation and action.
- b. Any such suspension or restriction imposed during an investigation or review shall be administrative and precautionary in nature and shall remain in effect, without the right to an appeal, during the investigation only, and shall not indicate the validity of the charges. The CEO, VPMA or Medical Staff President (or their designees) shall notify the Member of the suspension either by phone or in person as soon after imposition as practical. Written confirmation of the suspension shall thereafter be promptly sent to the Member. The precautionary suspension shall be in effect during an investigation to determine whether a professional review action is needed, but shall automatically cease at the end of the fourteenth day (14th) day following imposition unless sooner terminated,

lifted or extended as provided in these Bylaws.

The investigation shall be completed within fourteen (14) days of the suspension. If the investigation is not completed within such time, the MEC (or Board if the MEC is the body that imposed the precautionary suspension) shall consider the reasons for the delay and determine whether to continue the suspension. Unless the MEC or Board, as applicable, continues the suspension past the fourteen (14) days or one of the persons or bodies authorized to suspend the Clinical Privileges of a Member pursuant to Article 11, Section B takes such action to extend the suspension of Member's for the reasons set forth in Article 11, Section B, the suspension shall automatically terminate at the end of the fourteenth (14th) day after initial imposition.

However, nothing herein shall prohibit such suspension from thereafter being reimposed by any person or body authorized by these Bylaws to do so for the reasons set forth in these Bylaws. If the suspension is continued past the fourteen (14) days by action of the MEC or Board, the suspended Member shall have the procedural rights set forth in Article 12. For purposes of calculating the applicable deadlines under Article 12, the first day of the continuation is considered to be the first day of the suspension.

- c. In the event of a precautionary suspension of Privileges, the appropriate department chair, or, if unavailable, the Medical Staff President, shall immediately assign to another Medical Staff Member with appropriate Clinical Privileges, responsibility for the care of the patients of the suspended Member until the precautionary suspension has been lifted or such patients are discharged from the Hospital. Wherever possible, in the selection of a substitute Member, consideration should be given to the patient's wishes.
- d. Notwithstanding any other provision herein, the VPMA, Medical Staff President or CEO may suspend a Member for greater than fourteen (14) days if it determines during the investigation that failure to take such action may result in an imminent danger to the health of any individual. If such precautionary suspension exceeds thirty (30) days, the Member shall have a right to hearing and appeal as set forth in Article 12.

7. PROCEDURE UPON COMPLETION OF INVESTIGATION

- a. Upon completion of its investigation, or, if appropriate, at any time during its investigation, the ad hoc committee may do one or more of the following:
 - (i) Recommend that no action is justified;
 - (ii) Recommend that a requirement of consultation be imposed;
 - (iii) Recommend that a written warning or letter of reprimand be issued;

- (iv) Recommend medical treatment or therapy;
 - (v) Recommend that terms of probation be imposed;
 - (vi) Recommend a reduction or restriction on Privileges, in whole or in part;
 - (vii) Recommend suspension of Clinical Privileges for a specific period of time, including precautionary suspension and for such purpose may refer such recommendation directly to the VPMA or Medical Staff President pursuant to Article 11, Section B;
 - (viii) Recommend revocation of Medical Staff appointment or Clinical Privileges;
 - (ix) Refer the matter to the Missouri State Medical Association Physicians' Health Program or similar program, if appropriate; or
 - (x) Make such other recommendations as it deems necessary or appropriate.
- b. The chair of the ad hoc committee shall submit to the MEC a written report, setting forth the committee's findings, conclusions and recommendations. The committee shall be available to the MEC to answer any questions that may be raised with respect to its recommendation(s).

8. MEC ACTION ON AD HOC COMMITTEE'S REPORT

- a. The MEC shall meet as quickly as practical after receipt of the ad hoc committee's or Peer Review Committee's report (but in no event later than thirty (30) days) to consider its recommendations. The MEC may meet with the members of the ad hoc committee or the Peer Review Committee, and/or request specific information or findings therefrom. Upon conclusion of the MEC's evaluation of such report and information available to it, the MEC may: (i) adopt the recommendations in whole or in part; (ii) reject the recommendations in whole or in part; (iii) modify such recommendations; and/or (iv) adopt a recommendation of its own. Based upon its conclusions, the MEC may impose or take such action as recommended or impose or take any other action which it is empowered to take as provided in these Bylaws, including but not limited to those actions described in Article 11, Section A.7.
- b. If the MEC's recommendation or action would entitle the Member being investigated to request a hearing and appeal of such action or recommendation and the procedural rights provided in these Bylaws, such recommendation shall be forwarded to the CEO who shall promptly notify the affected Member by Special Notice of the recommendation or action. The CEO shall then hold the recommendation (except a precautionary suspension) until after the Member has been deemed to have waived the right to a hearing, or until after the Member has exercised such right and the process has been completed.
- c. If the action of the MEC would not entitle the Member to a hearing (for example, an action described in Article 12, Section A, the action shall take effect immediately without action of the Board and without the right of appeal as provided in these Bylaws. A report of the action taken and reasons therefor shall be made to the CEO.

9. BOARD ACTION

- a. If the action of the MEC is to recommend that action be taken by the Board and such recommendation either does not entitle the Member to a hearing and the procedural rights set forth in Article 12 or such procedural rights have been waived by the Member or have been concluded, the Board shall consider the recommendation of the MEC at its next regular meeting.
- b. In the event the Board initially determines to consider modification of the action of the MEC or takes action upon a recommendation of the MEC that had not previously entitled the Member to a hearing and the procedural rights set forth in Article 12 and such modification or action would entitle the Member to a hearing in accordance with these Bylaws, it shall so notify the affected Member, through the CEO, by Special Notice and shall take no final action thereon (except for a precautionary suspension of the Member as provided in these Bylaws) until the Member has had an opportunity to exercise the right to a hearing and appeal as provided in these Bylaws and such process has been completed.

B. PRECAUTIONARY (SUMMARY) SUSPENSION OF CLINICAL PRIVILEGES

1. GROUNDS FOR PRECAUTIONARY SUSPENSION

In lieu of the procedure set forth in Article 11, Section A (other than Article 11, Section A.6), the Medical Staff President, the VPMA, the chair of the applicable department, the MEC, the CEO, or the Chairman of the Board each shall have the authority to suspend all or any portion of the Clinical Privileges of a Member whenever such action is reasonably believed to be in the best interests of patient safety or care, the orderly operation of the Hospital or patient care, protection of the Hospital, or otherwise for the protection of the Hospital as authorized in any Medical Staff policy. Such suspension shall not imply any final finding of responsibility for the situation that prompted the suspension.

Such precautionary suspension shall become effective immediately upon imposition, shall immediately be reported in writing to the CEO, the Medical Staff President, the VPMA, the chair of the Credentials Committee, and the Member affected, and shall remain in effect unless or until modified by the MEC, the CEO, the Board, the person or body imposing such suspension, or as provided in this Section or after the procedures contained in Article 12 have been completed and such procedure has determined that such suspension be lifted.

Any individual or body which exercises authority under this Article 11, Section B to suspend the Clinical Privileges of a Member shall immediately report such action to the VPMA and CEO so that appropriate further action can be taken in the matter.

Without limiting the foregoing but as an illustration, the following are examples of grounds for imposition of a precautionary suspension:

- a. the conduct of the Member creates a reasonable possibility of injury or damage to any patient, employee or person present in the Hospital or to the Hospital;
- b. the Member is charged with the commission of a felony;

- c. the Member is charged with the commission of a misdemeanor which they may relate to the Member's suitability for Medical Staff appointment or Clinical Privileges;
- d. the Member engages in or is charged with unlawful or unethical activity related to the practice of medicine or his/her professional;
- e. the Member engages in any dishonest, unprofessional, abusive or inappropriate conduct which is or may be disruptive of Hospital operations and procedures;
- f. the Member has had any Medical Staff appointment, Clinical Privileges, certification, licensure or registration terminated, suspended, restricted, limited, reduced or modified in any way, has resigned from any other medical staff in order to avoid an investigation or proposed action concerning medical staff appointment or Clinical Privileges, or has voluntarily surrendered or agreed not to exercise any Clinical Privileges while under investigation or to avoid an investigation whether at Hospital or any prior hospital;
- g. it is determined that the Member made a material misstatement or omission on any application for appointment or reappointment, or at any time provided incorrect information or otherwise deceived or attempted to deceive or mislead the Medical Staff and/or the Hospital;
- h. the Member has falsified or inappropriately destroyed or altered any medical record;
- i. the Member refuses to submit to evaluation or testing relating to the Member's mental or physical status, including refusal to submit to any testing related to drug or alcohol use;
- j. the Member abandons a patient or wrongfully fails or refuses to provide care to a patient; or
- k. the Member engages in clinical activities outside the scope of the Member's approved Clinical Privileges.

2. INVESTIGATIVE PROCEDURE

An investigation of the matter resulting in precautionary suspension shall be immediately undertaken by the VPMA or his/her designee. Upon completion of his/her investigation, the VPMA (or his/her designee, as applicable) shall make a report to the Medical Staff President or his/her designee within seven (7) business days after the imposition of the precautionary suspension.

The MEC shall undertake its review as soon as possible upon receipt of the report of the investigation regarding imposition of the precautionary suspension. The MEC shall determine whether to continue or lift such suspension within fourteen (14) days of the date of imposition, and, in the event it determines to continue such suspension, shall so advise the CEO. In the event that the MEC fails to complete its investigation and determine whether to continue such suspension within said fourteen (14) days, the suspension shall be automatically lifted at the expiration of such fourteen (14) days, provided, however, nothing herein shall prohibit such suspension from thereafter being reimposed by any person or body authorized by these Bylaws to do so for the reasons set forth herein and provided further that if the MEC has completed its investigation it may determine to maintain such suspension indefinitely.

Upon completion of its review of the matter, the MEC shall ratify, modify or overrule the action taken by the individual or body which imposed the precautionary suspension. The suspended Member shall be entitled to the procedural rights provided in Article 12 in the event of any suspension which has not been lifted by the end of the fourteenth (14th) day after imposition or in the event of reimposition, unless the suspension was imposed in the reasonable belief that failure to impose the suspension may result in an imminent danger to the health of any individuals. In such cases, the Member shall not have a right to hearing or appeal until the suspension exceeds thirty (30) days.

3. CARE OF SUSPENDED MEMBER'S PATIENTS

Immediately upon the imposition of a precautionary suspension, the appropriate department chair or, if unavailable, either the Medical Staff President or the VPMA shall assign to another Member with appropriate Clinical Privileges responsibility for care of the suspended Member's patients still in the Hospital. The assignment shall be effective until such time as the suspension is lifted or the patient(s) are discharged from the Hospital. Whenever possible, the wishes of the patient shall be considered in the selection of the assigned appointee.

C. TEMPORARY OR ADMINISTRATIVE (AUTOMATIC) SUSPENSIONS

1. TEMPORARY SUSPENSIONS

A Member shall be deemed to have voluntarily relinquished his/her Clinical Privileges and be deemed to be under administrative suspension (without any procedural rights otherwise provided in this Manual) in the event that any of the following events shall have occurred (and during the duration thereof):

- a. Upon notification by the Medical Staff President, or his/her designee, of the Member's delinquency or failure to complete medical records within the applicable time periods in accordance with the Medical Staff Rules and Regulations and applicable Medical Staff policies, if any;
- b. Upon notification by the Medical Staff President, or his/her designee, of the expiration of Member's license;
- c. Upon Member's failure to provide copies of his DEA or BNDD registration renewal, if applicable to the Member's practice, because the Member has failed to timely submit paperwork required for the renewal. In such cases, the Member shall not prescribe or dispense medications that require a BNDD and/or DEA certificate. Notwithstanding, the MEC may review the matter and determine in its sole discretion that the Member's lack of BNDD and/or DEA certificate shall constitute grounds to administratively suspend all of the Member's Clinical Privileges, and the Member shall have no right to hearing or appeal;
- d. Upon probation, suspension or limitation of a Member's license for disciplinary or professional competency reasons, (then such appointment or Privileges are automatically suspended or limited to at least the same extent or greater, as determined by the MEC);

- e. Upon notification by the Medical Staff President, or his/her designee, of the Member's failure to maintain an alternate with equivalent Clinical Privileges as required in Article 6.
- f. If a Member's professional liability insurance coverage as required to be maintained in Article 6 of these Bylaws, is terminated, cancelled, non-renewed, lapses, or coverage terms are changed in any way creating a gap or gaps in coverage, or coverage is reduced below the required limits or coverage in the required limits is not maintained on each Privilege granted; and/or
- g. The Member or Applicant fails to participate in an evaluation of his/her qualifications for appointment or Privileges as required under these Bylaws (whether an evaluation of physical or mental health or of clinical management skills).
- h. The Member fails to receive an Influenza vaccination or an approved exemption, pursuant to Medical Staff policies regarding Influenza Vaccinations;
- i. The Member fails to pay Medical Staff dues within sixty (60) days of the date of the invoice; and/or
- j. Any other event that the MEC determines, in its sole discretion, warrants a Temporary or Administrative (Automatic) Suspension.

Unless otherwise provided above, upon correction of such deficiencies, if possible, the Member shall so notify the Medical Staff President or his/her designee. If the Medical Staff President agrees that such matter has been corrected he/she shall notify the Member that his/her administrative suspension has been lifted and his/her Clinical Privileges have been reinstated. However, in the event the Member fails to notify the Medical Staff President that he/she has corrected the basis for such suspension (and provided proof of the correction) within six (6) months from the effective date of suspension, the Medical Staff appointment of such Member and/or Clinical Privileges of such Member will be deemed voluntarily surrendered and terminated and such Member shall be deemed to have voluntarily resigned from the Medical Staff without any procedural rights under Article 12. Notwithstanding, if a Member is suspended under Article 11(C)(1)(f) (regarding insurance coverage) then the timeframe set forth herein shall be thirty (30) days instead of six (6) months.

2. **AUTOMATIC TERMINATION OF APPOINTMENT/CLINICAL PRIVILEGES**

A Member's Medical Staff appointment and Clinical Privileges shall automatically cease and terminate upon:

- a. Revocation of the Member's state license to practice, or voluntary relinquishment of the Member's state license to practice. Before such Member can reapply for Medical Staff appointment and Privileges, he/she must submit to the MEC all documentation related to such revocation or voluntary relinquishment for its review. The MEC may request additional information and require an appearance before the MEC by the Applicant to answer questions and provide information it deems relevant to the issue. The MEC shall determine whether the Applicant shall be eligible to reapply to the Medical Staff. If an Applicant's license has been revoked, the Applicant must re-apply, if appointment and/or Clinical Privileges are again desired, when/if the license is re-instated. However, if the license has been revoked solely due to failure to file

renewal forms and fees with the board of medical licensure or has expired in accordance with the provisions of the license issued, the Applicant will be placed on a leave of absence and his/her appointment may be re-instated upon adequate evidence of issuance of new license;

- b. A Member's conviction of, or pleading "guilty," "no contest," to or otherwise admits to any crime involving a morally corrupt act or practice, or any felony offense or other crime which reasonably relates to the ability of the Member to exercise Clinical Privileges, whether or not a sentence has been imposed or suspended, or whether probation has been granted, in any court of the United States (federal or state); or
- c. Upon the Member's exclusion from participation in the Medicare, Medicaid or other government sponsored healthcare program.

In the event any of the events described in this subsection shall occur, the Medical Staff appointment and Clinical Privileges of such Member will be deemed voluntarily surrendered and terminated and such Member shall be deemed to have voluntarily resigned from the Medical Staff, without any procedural rights under Article 12.

D. LEAVE OF ABSENCE

The process for a leave of absence shall be set forth in the Credentialing Procedures Manual.

E. PROCEDURE FOR RESIGNATION

A Member may resign his/her Medical Staff appointment or surrender all or part of his/her Clinical Privileges by providing written notice, through the Medical Staff Office, to the applicable department chairperson, VPMA or President of the Medical Staff. The resignation or surrender shall specify the reason for the resignation or surrender and the desired effective date. After examining the circumstances, outstanding obligations of the Member and needs of the Hospital, the MEC shall approve the effective date of such resignation. A Member who resigns his/her Medical Staff appointment and/or Clinical Privileges is obligated to fully and accurately complete all portions of all medical records for which he/she is responsible prior to the effective date of the resignation. Failure to so complete the Member's medical records or portion for which he/she is responsible shall result in an entry in the Member's credentials file acknowledging the resignation and indicating that it became effective under unfavorable circumstances and shall be considered a matter of professional conduct that could adversely affect the health or welfare of a patient and may be reportable under state or federal law.

F. CONFIDENTIALITY AND REPORTING

Actions taken and recommendations made pursuant to this Article shall be treated as confidential. In addition, reports of actions taken pursuant to this Article shall be made by the CEO to such governmental agencies as may be required by law.

G. PEER REVIEW PROTECTION

All minutes, reports, recommendations, communications, and actions made or taken pursuant to this Article are deemed to be covered by the provisions of the Missouri Peer Review Statute, Mo. Ann. Stat. § 537.035 or the corresponding provisions of any subsequent federal or state statute providing protection to peer review or related activities. Furthermore, the committees and/or panels charged with making reports, findings, recommendations or investigations pursuant to this Article shall be considered to be acting on behalf of the Hospital and its Board when engaged in such professional review activities and thus shall be deemed to be “professional review bodies” as that term is defined in the Health Care Quality Improvement Act of 1986.

H. INFORMAL PROCEEDINGS

Nothing in this Article or in these Bylaws shall preclude collegial or informal efforts to address questions or concerns relating to a Member’s practice and conduct in the Hospital. Documentation of such collegial intervention shall be included in the Member’s confidential peer review file. Collegial intervention efforts are not mandatory, and shall be within the discretion of the VPMA, appropriate department chair or Medical Staff President or his/her designee.

I. SUBSTANTIAL COMPLIANCE

Minor deviations from the procedures set forth in this Article 11 shall not be grounds for invalidating the action taken,

ARTICLE 12

HEARING AND APPEAL PROCEDURE

A. ACTIONS WHICH DO NOT GIVE RIGHT TO HEARING

No recommendation or action except those enumerated in Article 12, Section B and no action described in this Article 12, Section B shall constitute grounds for or entitle the Applicant or Member to request a hearing or appeal of the action. As examples and not as a limitation, none of the following matters shall entitle an Applicant or Member to a hearing under these Bylaws:

1. an oral or written reprimand, warning, or admonition;
2. imposition of a requirement that the Member must be supervised while performing certain procedures, unless such requirement prevents the Member from exercising his/her Privileges;
3. denial of requested Clinical Privileges because the Applicant or Member failed to satisfy the basic qualifications or criteria of training, education, experience (including performance of a minimum number of procedures or related procedures, if any) or, if applicable, departmental affiliation established for the granting of Privileges for a specific procedure or procedures, as set forth in the Medical Staff Manuals or any Medical Staff credentials policy or privileging criteria;
4. ineligibility for Medical Staff appointment or reappointment or the Clinical Privileges requested because there exists an exclusive contract limiting the performance of Privileges within the specialty in which the Applicant or Member has requested to one or more Physicians or Specialty Dentists;
5. ineligibility for Medical Staff appointment or reappointment because of lack of facilities or equipment for the service or procedure which the Applicant or Member intends to provide;
6. loss of Clinical Privileges and/or Medical Staff appointment because Member's exclusive contract with Hospital has been terminated for any reason or because a Member has been terminated or voluntarily resigned from a group who is under an exclusive contract with Hospital;
7. ineligibility for requested Clinical Privileges because the Hospital has elected not to perform, or does not provide, the procedure for which Clinical Privileges are sought;
8. reduction, suspension or revocation of Medical Staff appointment, category of appointment or Clinical Privileges or denial of Medical Staff or department reappointment because of the failure of the Member to comply with requirements of the Bylaws, including, but not limited to, any required attendance at committee, department, or general Medical Staff meetings, payment of required dues, compliance with medical records requirements, failure to maintain required insurance, exclusion from Medicare, Medicaid or other government sponsored healthcare program, or loss, revocation or suspension of state or other required licensure or registration;
9. reduction, suspension or revocation of Medical Staff appointment or category of appointment or denial of Medical Staff reappointment because of the Member's failure

to satisfy the requirements for appointment to the Medical Staff category to which appointment or reappointment was sought, as such requirements are set forth in Articles 3 and 4 of these Bylaws;

10. denial of initial appointment or reappointment to the Medical Staff or of the initial grant or renewal of Clinical Privileges because of the Applicant's or Member's failure to demonstrate evidence of the satisfaction of basic requirements for appointment or reappointment or granting of Clinical Privileges, including, but not limited to, licensure, maintenance or required professional liability insurance, Board Certification, or any other criteria for appointment or reappointment or granting of Clinical Privileges as set forth in these Bylaws;
11. voluntary suspension or relinquishment of Clinical Privileges or Medical Staff appointment, as provided for elsewhere in these Bylaws;
12. conviction of, or pleading guilty to a charge of, or entered a plea of no contest to a charge of, a felony which reasonably relates to the ability of the Member to exercise the Clinical Privileges granted, whether or not sentence was imposed;
13. imposition of any general consultation requirement so long as such requirement is not a condition to the exercise of Privileges;
14. the imposition of a requirement for retraining, additional training or continuing education;
15. the imposition of a requirement that the Applicant or Member must obtain a medical (including psychological) evaluation or counseling;
16. denial of a request for or termination or revocation of temporary, emergency, locum tenens or disaster Clinical Privileges;
17. proctoring and any other performance monitoring requirements requested by any individual or committee authorized by these Bylaws, so long as such requirements are not a condition to the exercise of Privileges;
18. suspension of Privileges, either in whole or in part, or Medical Staff appointment for fourteen (14) days or less and during which an investigation is being conducted to determine the need for further action;
19. termination or revocation of Medical Staff appointment or reduction, suspension, termination or revocation of Clinical Privileges either in whole or in part, because the Hospital has eliminated a category of the Medical Staff provided, however, that if Hospital eliminates a category of the Medical Staff, Member may apply to a different category of the Medical Staff;
20. Where the Applicant has deemed to have withdrawn his/her application for appointment, re-appointment or for Clinical Privileges pursuant to any provision of this Policy;
21. appointment or reappointment or granting of Clinical Privileges for a term of less than two (2) years;
22. revocation or termination of Clinical Privileges because the Hospital or Board has determined that certain procedures or practices will not be permitted to be performed in the Hospital;
23. placement on probationary or other conditional status;
24. continuation of Provisional status;
25. failure to place an Applicant or Member in any call-box or call schedule, or removal of any Applicant or Member from such call-box or call schedule;
26. termination of a Member's access to Hospital's electronic health record (EHR); or

27. any other action for which no hearing is required to be provided pursuant to the Health Care Quality Improvement Act of 1986 or any action or recommendation for which is not reportable to the National Practitioner Data Bank.

B. BASIS FOR HEARING

1. GENERAL GROUNDS FOR ENTITLEMENT TO HEARING

Except as otherwise specifically provided in these Bylaws, an Applicant or Member applying for or holding Clinical Privileges shall be entitled to request a hearing and appeal of certain actions or recommendations as described in and in accordance with these Bylaws whenever:

- a. an unfavorable recommendation has been made by, or adverse action taken by, or adverse action has been approved by the MEC and/or the Board (except as provided in Article 12, Section A) regarding any of the following:
 - (i) denial of initial Medical Staff appointment or reappointment;
 - (ii) revocation/termination of Medical Staff appointment;
 - (iii) involuntary reduction, restriction, revocation or denial of Privileges or requested additional Privileges (other than Temporary Privileges, Emergency Privileges, or Disaster Privileges) provided the Member has satisfied the basic criteria of training, education, experience and, if applicable, departmental affiliation established for such Privileges;
 - (iv) suspension of Medical Staff appointment or Clinical Privileges, either in whole or in part, for a period in excess of fourteen (14) days unless otherwise provided in these Bylaws;
 - (v) denial of a request to return to active Medical Staff status following a temporary leave of absence; or
 - (vi) such other adverse action or recommendation which requires, under applicable law, giving an Applicant or Member the right to a hearing.

Notwithstanding anything contained in Article 12, Section A or Article 12, Section B, if the MEC upon conclusion of any investigation while a precautionary suspension is pending removes or terminates such suspension and restores the Member's Clinical Privileges prior to the thirty-first (31st) day after imposition of such suspension, the affected Member shall have no right to seek review or appeal of such action. If a request for an appeal has been made prior to removal or termination of such suspension, such request for appeal shall be deemed withdrawn and of no further effect.

2. MUST BE ACTION BY CERTAIN PERSONS, COMMITTEES OR THE BOARD

A recommendation or action enumerated in Article 12, Section B shall entitle an Applicant or Member to a hearing only when it:

- a. has been recommended by, the action has been taken by, or the action has been approved by the MEC;
- b. has been recommended by or the action has been taken by the Board contrary to a favorable recommendation by the MEC under circumstances where no prior right to a hearing existed;
- c. has been recommended by or the action has been taken by the Board on its own initiative without benefit of a prior recommendation by the MEC; or
- d. constitutes action described in Article 12, Section B.1.a.iv (continuation of suspension beyond fourteen (14) days).

3. NOTICE OF ADVERSE ACTION OR RECOMMENDATION

When an action or recommendation is made which, according to these Bylaws, entitles an Applicant or Member to appeal such action or recommendation and seek a hearing prior to a final decision of the Board, the affected Applicant or Member shall promptly be given Special Notice by the Chief Executive Officer of such action or recommendation. This notice shall contain:

- a. a statement of the recommendation made or action taken and the general reasons or basis for such action or recommendation;
- b. advice that the Applicant or Member has the right to request a hearing on the recommendation or action taken within thirty (30) days of receipt of the notice;
- c. a notice that failure to request a hearing within thirty (30) days shall constitute a waiver of the right to a hearing and to any appellate review of the matter and shall be deemed acceptance of the recommendation or action;
- d. a notice that upon Hospital's receipt of a hearing request, the Applicant or Member will be given notice of the date, time and place of the hearing;
- e. a summary of the Applicant's or Member's rights in the hearing; and
- f. a copy of this Article outlining the rights in the hearing procedure as provided for in these Bylaws.

4. REQUEST FOR HEARING

An Applicant or Member shall have thirty (30) days following the date of receipt (which date shall also mean the date of any attempted or refused delivery) of the Special Notice given pursuant to Article 12, Section B.6 within which to request the hearing. The request shall be in writing delivered to the CEO or his/her designee either in person or by United States certified or registered mail and must be postmarked within the thirty (30)-day period. If the Applicant or Member wishes to be represented by an attorney at the hearing, his/her request for a hearing must so state.

5. WAIVER BY FAILURE TO REQUEST A HEARING

If an Applicant or Member fails to appeal such action by requesting a hearing within the time and in the manner specified in Article 12, Section B.4, the Applicant or Member shall be deemed to have waived any right to appeal the action taken or recommendation

and to such hearing or appellate review and to have accepted the action or recommendation involved. Such waiver in connection with:

- a. an adverse recommendation or action by the Board shall constitute acceptance of that action, which shall thereupon become effective as the final decision of the Board; or
- b. an adverse recommendation by the MEC or action by a person or body authorized by these Bylaws to take action which prompted the right to a hearing shall constitute acceptance of that recommendation or action, which shall thereupon become and remain effective pending the final decision of the Board. Unless such recommendation or action shall have been made by the MEC or the Board, such action or recommendation shall be considered by the MEC at its next regular meeting following the effective date of such waiver and the MEC shall report its recommendation to the Board. The Board shall consider the Committee's recommendation at its next regular meeting following the effective date of such waiver or meeting of the MEC as provided in the immediately preceding sentence. In its deliberations, the Board shall review the recommendation and may consider all relevant information from such Committee or from any other source. If the Board's action on the matter is in accord with the MEC's recommendation, such action shall constitute the final decision of the Board. If the Board's action has the effect of changing the MEC's recommendation in any material respect, the matter shall be submitted to a Joint Conference Review Committee as provided in Article 12, Section B.11.h.ii. The Board's action on the matter following receipt of the Joint Conference Review Committee's recommendation shall constitute its final decision.

6. NOTICE OF HEARING AND STATEMENT OF REASONS

- a. As soon as practical after receipt of a request for a hearing from the affected Applicant or Member, the CEO or his/her designee shall schedule the date upon which the hearing shall be held and shall advise the Applicant or Member by Special Notice not less than thirty (30) days prior to the scheduled hearing date (except in the case of a hearing for an Applicant or Member who is under a suspension then in effect, in which event such notice shall be given not later than ten (10) days prior to the scheduled hearing date if the Applicant or Member has requested an expedited hearing), of the following:
 - (i) the time, place and date of the hearing;
 - (ii) a proposed list of witnesses, so far as are then known, who are expected to give testimony or present evidence at the hearing in support of the action taken or recommended by the MEC or the Board, as applicable, including a brief summary of their expected testimony; and
 - (iii) a statement of the Applicant's or Member's alleged acts or omissions and/or the specific reasons or the subject matter which is the basis for the recommendation or action, together with the list of specific or representative patient records, if applicable, and description of the incident(s) or other information supporting the recommendation or action.

This statement, the list of supporting patient record numbers, if applicable, witness list, and other supporting information may be amended or added to at any time, even during the hearing, so long as the additional material is relevant and the Applicant or Member and his/her counsel, if represented, shall have sufficient time to study this additional information to be able to rebut it.

- b. The hearing date shall be scheduled by the CEO or his/her designee as soon as practicable but no sooner than thirty (30) days nor more than sixty (60) days after the date of receipt by the CEO of the request for a hearing. However, a hearing for an Applicant or Member who is under current suspension shall be scheduled by the CEO or his/her designee and held as soon as the arrangements for it may reasonably be made if so requested by the Applicant.

7. WITNESS LISTS

At least fifteen (15) days before the hearing (but in no event less than five (5) days prior to the scheduled date of the hearing in the event of a hearing for an Applicant or Member then under suspension if the hearing has been expedited at the request of the Applicant or Member), the Applicant or Member requesting the hearing shall provide a written list of the names and addresses of the individuals expected to offer testimony or present evidence on his or her behalf including a brief summary of their testimony. In keeping with the purpose of the hearing, patients and patients' relatives should not ordinarily be called as witnesses. Patients and patients' relatives shall not be called as character witnesses. Patients and patients' relatives may, however, be permitted to testify only if the evidence to be provided by the patient or patients' relatives relates directly to any incident or matter of which they have direct knowledge and the subject of their testimony could not reasonably be adequately provided by available healthcare providers and is not otherwise attainable.

The witness list of either party may, in the discretion of the Hearing Officer or Presiding Officer, be supplemented or amended at any time either prior to or during the course of the hearing, provided that notice of the change is given to the other party. The Hearing Officer or Presiding Officer shall have the authority to limit the number of witnesses as set forth in Article 12, Section B.H.b.

8. HEARING PANEL, PRESIDING OFFICER AND HEARING OFFICER

- a. Hearing Panel

When a hearing which is occasioned by an action or recommendation which entitles an Applicant or Member to a hearing pursuant to Article 12, Section B (except action taken or recommended by the Board), is requested, the CEO, acting for the Board and after considering the recommendations of the Medical Staff President, unless the subject of the hearing, shall appoint a Hearing Panel which shall be composed of not less than three (3) members, which may include appointment of one or more alternates. The Hearing Panel shall be composed of

at least three (3) Active Medical Staff Members who have not actively participated in the consideration of the matter involved at any previous level. Any member of the Hearing Panel, including any alternate, who participates in the entire hearing, or reviews the transcript of any portions of the hearing for which the panel member is not in personal attendance, may be permitted to participate in the deliberations and to vote on the recommendations of the Hearing Panel.

When a hearing which is occasioned by the action or recommendation of the Board pursuant to Article 12, Section B or Section C is requested, the CEO, acting for the Board and after considering the recommendations of the Medical Staff President, unless the subject of the hearing, shall appoint a Hearing Panel which shall be composed of not less than three (3) members, which may include the appointment of one or more alternates. The Hearing Panel may be composed of (i) Active Medical Staff Members who have not actively participated in the consideration of the matter involved at any previous level, (ii) members of the Board who shall not have actively participated in the matter involved, or (iii) any combination thereof. Any member of the Hearing Panel, including any alternate, who participates in the entire hearing, or reviews the transcript of a any portions of the hearing for which the panel member is not in personal attendance, may be permitted to participate in the deliberations and to vote on the recommendations of the Hearing Panel.

The Hearing Panel shall not include any individual who is in direct economic competition with the affected Applicant or Member or any such individual who is related to the affected Applicant or Member. Such appointment shall include designation of one of the members of the Hearing Panel as the chair or the Presiding Officer who shall act with the consent of and on behalf of the Hearing Panel. Knowledge of the matter involved, or participation in the investigation of the underlying matter, shall not preclude any individual from serving as a member of the Hearing Panel.

The Applicant or Member shall be notified of the prospective members of the Hearing Panel, and if the Applicant or Member has any objection to any proposed panel member, the Applicant or Member shall, within ten (10) calendar days after notification, state the objection in writing and the reasons for the objection. The Medical Staff President and the CEO shall, after considering such objections, decide in their discretion whether to replace any person objected to, and the Applicant or Member shall be notified of the final members of the Hearing Panel.

The Hearing Panel may make a recommendation to the MEC (or the Board as the case may be) as long as a majority of the panel members, including any alternates, have attended all the hearings or read the transcript of any hearings for which a panel member was not in personal attendance. A majority of the members of the Hearing Panel, including any alternates shall constitute a quorum for purposes of conducting a hearing.

b. Presiding Officer

In lieu of appointing a member of the Hearing Panel as chair, the CEO may appoint an attorney at law, including a judge or retired judge, as Presiding Officer. Such Presiding Officer may be legal counsel to the Hospital, but shall not act as a prosecuting officer, or as an advocate for either party at the hearing. The Presiding Officer may participate in the private deliberations of the Hearing Panel and be a legal advisor to it, but shall not be entitled to vote on its recommendations. Legal counsel may thereafter continue to advise the Board on the matter.

If no Presiding Officer has been appointed, a chair of the Hearing Panel shall be appointed by the CEO, shall serve as the Presiding Officer, and shall be entitled to one (1) vote.

The Presiding Officer or Hearing Panel Chair (collectively “Presiding Officer”) shall:

- (i) act in an impartial manner to ensure that all participants in the hearing have a reasonable opportunity to be heard and to present relevant oral and documentary evidence subject to reasonable limits on the number of witnesses and duration of direct and cross examination, applicable to both parties, as may be necessary to avoid cumulative or irrelevant testimony or to prevent abuse of the hearing process;
- (ii) maintain decorum throughout the hearing;
- (iii) determine the order of procedure throughout the hearing, including limiting duplicative or redundant testimony and witnesses or testimony which is not deemed relevant to the issue presented, and excluding expert witnesses or others during the proceedings when they are not providing testimony;
- (iv) have the authority and discretion, in accordance with these Bylaws, to make rulings on all questions which pertain to matters of procedure and to the admissibility of evidence;
- (v) act in such a way that all information relevant to the continued appointment or Clinical Privileges of the Applicant or Member requesting the hearing is considered by the Hearing Panel in formulating its recommendations; and
- (vi) conduct argument by counsel on procedural points outside the presence of the Hearing Panel unless the panel wishes to be present;

The Presiding Officer may be advised by legal counsel to the Hospital or other counsel engaged for the purpose of advising the Hearing Panel and/or the Presiding Officer.

c. Hearing Officer

As an alternative to the Hearing Panel described in Article 12, Section B.8.a, the CEO, after consulting with the Medical Staff President (and Chairman of the

Board if the hearing was occasioned by a Board determination) may instead appoint a Hearing Officer to perform the functions that would otherwise be performed by the Hearing Panel. The Hearing Officer shall preferably be an attorney at law (who may also be legal counsel to the Hospital), including a judge or former judge, or some other individual capable of conducting a hearing.

The Hearing Officer may not be in direct economic competition with the Applicant or Member requesting the hearing, and shall not act as a prosecuting officer or as an advocate to either party at the hearing.

In the event of the appointment of a Hearing Officer as provided in this subparagraph, the CEO shall immediately notify the affected Applicant or Member of such action and the identity of such person who shall be reasonably acceptable to the Applicant or Member. In the event such person is unacceptable to the Applicant or Member, the Applicant or Member shall so advise the CEO within ten (10) days (and the Applicant or Member shall be notified of such duty and right) of his or her objection and the basis therefor, which shall not be arbitrary or unreasonable. Failure to so object within said ten (10) days shall be deemed as acceptance of such Hearing Officer. If the CEO accepts the basis for the Applicant's or Member's objection and desires to appoint a substitute Hearing Officer, the CEO and affected Applicant or Member shall agree on such person. The CEO may elect, however, not to appoint a substitute Hearing Officer, in which event a Hearing Panel shall be appointed as otherwise provided herein as quickly as reasonably possible.

9. **HEARING PROCEDURE**

a. Nature of Hearing

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

b. Pre-Hearing Conference

Prior to the scheduled date of the hearing, the Hearing Officer or Presiding Officer, as applicable, shall schedule a conference between the Applicant or Member and representatives of the Medical Staff or Board, as applicable, and/or their counsel to discuss preliminary matters concerning the hearing in order that the hearing may be conducted in an orderly and expeditious fashion. The Hearing Officer or Presiding Officer may rule on preliminary matters and define the scope of the hearing, including any limitations on witnesses (either number or subject matter and whether certain witnesses shall be excluded during portions of the hearing), objections to documents or witnesses (as provided in Article 12, Section B.8.b), and whether the evidence relating to other Applicants or Members will be admissible.

The Hearing Officer or Presiding Officer, as applicable, shall advise the parties of his/her preliminary rulings with respect to evidentiary matters such as, but not

limited to, whether summaries of patient charts or the entirety of the patient charts would be submitted in evidence or offered to the Hearing Officer or Hearing Panel, any limitations on witnesses (either as to subject or number), any rulings as to documents and generally as to other evidence that may be submitted to the Hearing Officer or Hearing Panel. Within seven (7) days after receipt by the Hearing Officer or Hearing Panel of such information, the parties shall inform the Hearing Officer or Presiding Officer of any objections or concerns they have as to such preliminary rulings made. The Hearing Officer or Presiding Officer will discuss any objections or concerns so made (and the Presiding Officer shall discuss the objections or concerns with the Hearing Panel) and will resolve any such objections or concerns. Upon reaching agreement with the Hearing Officer or Presiding Officer as to such preliminary rulings, the Hearing Officer or Presiding Officer shall then promptly communicate the final ruling to the parties.

c. Pre-Hearing Discovery

There shall be no right to pre-hearing discovery for either party nor any right to seek information regarding other Members. Nothing shall prevent either party, however, from otherwise preparing its position, including interviewing witnesses (subject to the limitations in this Section) and obtaining statements therefrom. The Applicant or Member requesting the hearing shall be entitled, upon specific request, to the following, subject to a stipulation signed by both parties that such documents shall be maintained as confidential and shall not be disclosed or used for any purpose outside of the hearing:

- (i) copies of, or reasonable access to, all patient medical records referenced in the statement of reasons, at the Applicant's or Member's expense;
- (ii) reports of experts relied upon by the MEC, or Board, as the case may be;
- (iii) redacted copies of relevant committee or department minutes (such provision shall not constitute a waiver of the state peer review protection statute, however); and
- (iv) copies of any other documents relied upon by the MEC, or Board, as the case may be.

Upon specific request by the representatives of the Medical Staff or Board, as applicable, Applicant or Member shall provide the following, subject to a stipulation signed by both parties that such documents shall be maintained as confidential and shall not be disclosed or used for any purpose outside of the hearing:

- (i) reports of experts relied upon by the Applicant or Member; and
- (ii) copies of any other documents relied upon by the Applicant or Member.

Prior to the hearing, on dates set by the Hearing Officer or Presiding Officer or agreed upon by both parties or, if represented by counsel, counsel for both parties, each party shall provide the other party with a list of proposed exhibits. All objections to documents or witnesses, to the extent then reasonably known shall be submitted in writing in advance of the hearing. The Hearing Officer or Presiding Officer shall not

entertain subsequent objections unless the party offering the objection demonstrates good cause.

Neither the affected Applicant or Member, nor his/her attorney, if represented, nor anyone else on his/her behalf shall contact Hospital employees concerning the subject matter of the hearing, unless such is specifically agreed upon by counsel for the Hospital.

d. Failure to Appear

Failure, without good cause, of the Applicant or Member requesting the hearing to appear and proceed at such a hearing shall be deemed to constitute a withdrawal of the Applicant's or Member's request for a hearing and waiver of the Applicant's or Member's rights to appeal the adverse action or recommendation and shall further constitute a voluntary acceptance of the recommendations or actions pending in the same manner and with the same consequences as provided in Article 12, Section B.5.

e. Record of Hearing

The Hearing Officer or Presiding Officer shall maintain a record of the hearing by a reporter present to make a record of the hearing or a recording of the proceedings. The cost of such reporter shall be borne by the Hospital, but copies of the transcript shall be provided to the Applicant or Member requesting the hearing at the Applicant's or Member's expense. The Hearing Officer or Presiding Officer may, but shall not be required to, order that oral evidence shall be taken only on oath or affirmation administered by any person designated by such body and entitled to notarize documents in this State.

f. Rights of Both Parties

At the hearing both parties shall have the following rights, subject to reasonable limits determined by the Hearing Officer or Presiding Officer:

- (i) to make a brief opening statement to describe generally the nature and subject of the hearing in order to provide the Hearing Officer or Hearing Panel with an overview of the matter;
- (ii) to call and examine witnesses to the extent available;
- (iii) to introduce exhibits and present other evidence which is determined by the Hearing Officer or Presiding Officer to be relevant to the hearing in accordance with this Article;
- (iv) to cross-examine any witness on any matter relevant to the issues and to rebut any evidence;
- (v) to representation by counsel licensed to practice in Missouri who may call, examine, and cross-examine witnesses and present the case. Counsel shall not be allowed to answer questions directed to the Applicant or Member. The affected Applicant or Member may elect, as an alternative, to be represented by another person of the Applicant's or Member's

choice. Both parties shall notify the other of the name of their counsel (or other representative as the case may be) at least ten (10) days prior to the date of the hearing (five (5) days in case of a hearing scheduled sooner than thirty (30) days after receipt of the request for a hearing), provided, however, that either party may change such counsel at any time without prejudice; and

- (vi) to submit a written statement at the close of the hearing or within not later than five (5) business days after the close of the hearing, as determined by the Hearing Officer or Presiding Officer.

If the Applicant or Member who requested a hearing does not testify in his or her own behalf, the Applicant or Member may be called and examined as if under cross-examination.

g. Admissibility of Evidence

The hearing shall not be conducted strictly in accordance with the rules of evidence. Hearsay evidence shall not be excluded merely because it constitutes hearsay. Any relevant evidence upon which responsible persons are accustomed to rely in the conduct of serious affairs shall be admitted, regardless of the admissibility of such evidence in a court of law unless limited pursuant to Article 12, Section B.9.b or otherwise by the Hearing Officer or Presiding Officer. Each party shall have the right to submit a memorandum concerning any issue of law or fact, and points and authorities supporting it, and such memorandum shall become part of the hearing record. The Hearing Officer or Presiding Officer may request such a memorandum to be filed, following the close of the hearing by a date determined by the Hearing Officer or Presiding Officer. The Hearing Officer or Hearing Panel may question the witnesses, call additional witnesses or request documentary evidence if it deems it appropriate.

Peer review investigations, findings, documentation and related information regarding other Members are not relevant and, thus, are not admissible for any purpose.

h. Official Notice

The Presiding Officer shall have the discretion to take official notice, either before or after the submissions of the matter for decision, of any matters, either technical or scientific, relating to the issues under consideration and of any facts that could have been judicially noticed by the courts of the State of Missouri. Participants in the hearing shall be informed of the matters to be officially noticed and such matters shall be noted in the hearing record. Either party shall have the opportunity, if timely made, to request that a matter be officially noticed or to refute the noticed matter by evidence or by written or oral presentation of authority, the sufficiency of presentation to be determined by the Hearing Officer or Presiding Officer. The Hearing Officer or Hearing Panel shall also be entitled to consider any pertinent material contained on file in the Hospital and all other

information that can be considered pursuant to these Bylaws in connection with applications for appointment or reappointment to the Medical Staff or for the granting of Clinical Privileges.

i. Presence of Hearing Panel Members and Vote

A majority of the Hearing Panel including alternates must be present throughout the hearing and deliberations. If a panel member is absent from any part of the proceedings, he or she may not participate in the deliberations or the decision.

j. Postponements and Extensions

Postponements and extensions of time beyond any time limit set forth in these Bylaws may be requested by anyone but shall be permitted only by the Hearing Officer or Presiding Officer on a showing of good cause, except upon the agreement of both parties and except that the Applicant or Member shall be granted a request for a later hearing when the action involves an Applicant or Member who is under suspension then in effect and an early hearing had previously been set if the Applicant or Member believes he/she needs additional time to prepare for such hearing. Under exceptional circumstances, requests for postponement may be considered for no longer than thirty (30) days per postponement request, not to exceed a maximum of ninety (90) days after the CEO receives the initial request for postponement from the Applicant or Member.

10. HEARING CONCLUSION, DELIBERATIONS, AND RECOMMENDATIONS

a. Burden of Proof

The MEC or the Board, depending on whose recommendation prompted the hearing initially, shall first present evidence in support of its recommendation or action. Thereafter, the burden shall shift to the Applicant or Member who requested the hearing to present evidence.

After all the evidence has been presented by both parties, the Hearing Officer or Hearing Panel shall recommend in favor of the body whose action prompted the hearing unless it finds that the Applicant or Member who requested the hearing has proved, by clear and convincing evidence, that the recommendation or action that prompted the hearing was arbitrary, unreasonable, capricious, or not supported by any rational basis.

b. Basis of Decision

The decision of the Hearing Officer or Hearing Panel shall be based on the evidence produced at the hearing including matters to which official notice was taken and shall not be limited to the evidence before the body whose action prompted the hearing in determining whether such action was arbitrary,

unreasonable, capricious, or not supported by any rational basis. This evidence may consist of the following:

- (i) oral testimony of witnesses;
- (ii) memoranda concerning any issue of law or fact and points and authorities supporting it presented in connection with the hearing;
- (iii) any information regarding the Applicant or Member who requested the hearing so long as that information has been admitted into evidence at the hearing and the person who requested the hearing had the opportunity to comment on and, by other evidence, refute it;
- (iv) any and all applications, references, and accompanying documents;
- (v) other documented evidence, including medical records; and
- (vi) any other evidence that has been admitted, including matters to which official notice was taken.

c. Adjournment and Conclusion

The Hearing Officer or Presiding Officer may adjourn or recess the hearing and reconvene the same without additional notice at the convenience and with the agreement of the participants or for the purpose of obtaining new or additional evidence or consultation without additional notice. Upon conclusion of the presentation of oral and written evidence, including any new or additional evidence or consultation and any closing statements or summary made after conclusion of the hearing as directed by the Hearing Officer or Presiding Officer, the hearing shall be closed.

d. Deliberations and Recommendation of the Hearing Panel and Disposition of Hearing Panel Report

Within twenty (20) days after final closing and adjournment of the hearing, the Hearing Officer or Hearing Panel shall conduct its deliberations outside the presence of any other person (except the Presiding Officer, if one is appointed) and shall render a recommendation, accompanied by a report, which shall contain a concise statement of the reasons for the recommendation. Such report shall contain the Hearing Officer's or Hearing Panel's findings and recommendations.

Within ten (10) days after its completion, the Hearing Officer or Hearing Panel shall deliver the report, together with the hearing record and all other documentation considered by it, to the CEO who shall forward it, along with all such supporting documentation, to the Board if its adverse action or recommendation prompted the hearing, or to the MEC, if its action or recommendation prompted the hearing, for further action.

e. Action on Hearing Officer's or Hearing Panel's Report

The MEC or the Board, as the case may be as provided in this Article 12, shall consider the report of the Hearing Officer or Hearing Panel at its next regularly

scheduled meeting (but not later than thirty (30) days after receipt of the report). The MEC or Board, as applicable, shall affirm, modify or reverse its previous recommendation or action in the matter. It shall transmit notice of its action and the basis for its action, together with the hearing record, the report of the Hearing Officer or Hearing Panel and all other documentation considered, to the CEO.

f. Notice and Effect of Results

(i) Effect of Favorable Result

- (1) Adopted by the MEC: If the MEC's findings pursuant to this Section are favorable to the Applicant or Member, the CEO shall promptly forward such findings, together with all supporting documentation, to the Board for its final action. The Board shall take action thereon by adopting or rejecting the MEC's recommendation in whole or in part, or by referring the matter back to the MEC for further reconsideration. Any such referral back shall state the reasons therefor, set a time limit within which a subsequent recommendation to the Board must be made, and may include a directive that an additional hearing be conducted to clarify issues that are in doubt. After receipt of such subsequent recommendation and any new evidence in the matter, the Board shall take final action. The CEO shall promptly send the Applicant or Member Special Notice informing the Applicant or Member of each action taken pursuant to this subparagraph (1) and his/her right to request a copy of the recommendation of the MEC and the Board.

Favorable action shall become the final decision of the Board, and the matter shall be considered finally closed. If the Board's action is adverse in any of the respects listed in Article 12, Section B, Applicant or Member shall be informed by Special Notice of his/her right to request an appellate review by the Board as provided in Article 12, Section C.

- (2) Adopted by the Board: If the Board's action or recommendation prompted the hearing and, thus, is considering the recommendation of the Hearing Officer or Hearing Panel, it shall take action thereon by adopting or rejecting the Hearing Officer's or Hearing Panel's recommendation in whole or in part, or by referring the matter back to the Hearing Officer or Hearing Panel for further reconsideration. Any such referral back shall state the reasons therefor, set a time limit within which a subsequent recommendation to the Board must be made, and may include a directive that an additional hearing be conducted to clarify issues that are in doubt. After receipt of such subsequent recommendation and any new evidence in the matter, the Board

shall take final action. If the Board's action pursuant to Article 12, Section B.11 is favorable to the Applicant or Member, such result shall become the final decision of the Board and the matter shall be considered finally closed. The Applicant or Member shall be so notified of the action taken and of the Applicant's or Member's right to request a statement of the basis for the decision.

(ii) Effect of an Adverse Result

If the action of the MEC or of the Board pursuant to subparagraph a continues to be adverse to the Applicant or Member in any of the respects listed in Article 12, Section B, the Special Notice required by subparagraph (iii) shall inform the Applicant or Member of his/her right to request an appellate review by the Board as provided in Article 12, Section C.

(iii) Notice

The CEO shall promptly advise the Applicant or Member by Special Notice of the action taken by the MEC or the Board, as the case may be, and shall also advise the Medical Staff President and the Board, if such action was of the MEC. The Applicant or Member shall be furnished, upon request, a copy of the written recommendation of the MEC or the Board and of the Hearing Officer or Hearing Panel and the basis for the Hearing Officer's or Hearing Panel's recommendation.

11. INITIATION AND PREREQUISITES OF APPELLATE REVIEW

a. Request for Appellate Review

An Applicant or Member shall have fifteen (15) days following his/her receipt of the notice pursuant to Article 12, Section B.11.g to file a written request for an appellate review. Such request shall be in writing delivered to the CEO either in person or by certified or registered mail, postmarked within the fifteen (15) day time period, shall include a brief statement of the basis or reasons for appeal and may include, if desired, a request for a copy of the report and record of the Hearing Officer or Hearing Panel and all other material, favorable or unfavorable, that was considered in making the adverse recommendation or finding.

b. Grounds for Appeal

The grounds for appeal shall be as follows:

- (i) there was substantial failure to comply with these Bylaws prior to the hearing so as to deny due process or a fair hearing; or
- (ii) the recommendations were made arbitrarily, unreasonably, or capriciously; or

(iii) the recommendations were not supported by any rational basis.

c. Waiver By Failure to Request Appellate Review

An Applicant or Member who fails to request an appellate review within the time and manner specified in Article 12, Section C waives any right to such review. If an appellate review is not requested as provided in Article 12, Section C, such failure shall be deemed to be an acceptance of the recommendation or action involved, which action shall become effective immediately upon final Board action.

d. Notice of Time and Place for Appellate Review

Whenever an appellate review is requested in the manner set forth in the preceding sections, the CEO shall deliver such request to the Chairman of the Board. Within fifteen (15) days after receipt of such request, the Chairman of the Board shall schedule and arrange for an appellate review which shall be scheduled within thirty (30) days of receipt of the appellate review request; provided, however, that an appellate review for an Applicant or Member who is under suspension then in effect shall be held as soon as reasonably practical. The CEO or his/her designee shall send the Applicant or Member Special Notice of the date, place and time of the review no later than fifteen (15) days (seven (7) days when the action involves current a suspension) prior to the scheduled date for the appellate review. The time for the appellate review may be extended by the Appellate Review Body defined below for good cause.

e. Composition of Appellate Review Body

The appellate review shall be conducted by an appellate review committee (the "Appellate Review Body") composed of not less than three (3) nor more than seven (7) persons, who may be members of the Board or such other persons, including but not limited to reputable persons outside the Hospital, appointed by the Chairman of the Board to consider the record upon which the recommendation before it was made. One of the committee members shall be designated as chair.

f. Nature of Proceedings

The Appellate Review Body shall conduct its review based on its examination of the record of the hearing before the Hearing Officer or Hearing Panel, including its report, and all subsequent results, actions and written statements or documentation presented during the hearing process prior to appeal.

The Appellate Review Body may accept additional oral or written evidence (subject to the same rights of cross-examination or confrontation provided at the hearing level) only if the party seeking to admit new evidence can demonstrate being deprived of the opportunity to admit it at the hearing which preceded this appellate review.

Each of the parties in the matter shall have the right to submit a written statement detailing the findings of fact, conclusions and procedural matters with which he/she disagrees, and his/her reasons for such disagreement. This written statement may cover any matters raised at any step in the hearing process, and legal counsel may assist in its preparation. The statement shall be submitted to the Appellate Review Body through the CEO at least ten (10) days prior to the scheduled date of the appellate review. The MEC or Board may submit a reply, which shall be provided to the Applicant or Member by the CEO or his/her designee at least five (5) days prior to the appellate review.

The Appellate Review Body, in its sole discretion, may allow the parties or their representatives to personally appear and make oral statements in favor of their positions. Any party or representative appearing shall be required to answer questions put to him/her by any member of the Appellate Review Body.

The chair of the Appellate Review Body shall be the presiding officer. He/she shall determine the order and procedure during the review, make all required rulings, and maintain decorum.

The Appellate Review Body shall have all powers granted to the Hearing Officer or Hearing Panel, and such additional powers as are reasonably appropriate to the discharge of its responsibilities.

The Appellate Review Body may recess and review proceedings and reconvene the same without additional notice for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of the hearing, the appellate review shall be closed, and the Appellate Review Body shall conduct its deliberations outside the presence of the parties. Upon the conclusion of those deliberations, the appellate review shall be declared finally adjourned except in the event of referral back to the Hearing Officer or Hearing Panel as provided in Article 12, Section B.11.h, below. Unless the Appellate Review Body refers the matter back to the Hearing Officer or Hearing Panel, the Appellate Review Body will make its recommendation to the Board within thirty (30) days of its final conclusion of its review.

g. Action Taken

The Appellate Review Body may recommend that the Board affirm, modify or reverse the adverse result or action taken by the MEC or by the Board, as applicable, pursuant to Article 12, Section B.11., or, in its discretion, may refer the matter back to the MEC, Hearing Officer or Hearing Panel for further review and recommendation to be returned to it within forty-five (45) days and in accordance with its instructions. Within thirty (30) days after receipt of such further recommendation after referral, the Appellate Review Body shall make its recommendation to the Board as provided in this Article 12, Section B.

The appellate review shall not be deemed to be concluded until all of the procedural steps provided in this Article 12, Section B have been completed or waived.

h. Board Action

(i) Initial Action

Within forty-five (45) days after the conclusion of the appellate review, the Board shall render its decision in writing and shall send notice to the Applicant or Member by Special Notice, to the Medical Staff President, and to the MEC. The Board may affirm, modify or reverse the recommendation of the Appellate Review Body or, in its discretion, refer the matter for further review and recommendation. If the Board approves the last recommendation of the MEC, if any, it shall be immediately effective and final. If the Board's action has the effect of changing the last recommendation of the MEC, if any, the Board shall refer the matter to a Joint Conference Review Committee as provided in Article 12, Section B.11.h.ii.

(ii) Joint Conference Review Committee

The Joint Conference Review Committee shall consist of equal numbers of Active Medical Staff Members and Board members who shall be appointed by the Chairman of the Board after consultation with the Medical Staff President. One of its members shall be designated as chair. Within twenty (20) days of its receipt of a matter referred to it by the Board, the Joint Conference Review Committee shall convene to consider the matter and shall submit its recommendation in writing to the Board no later than thirty (30) days thereafter.

(iii) Final Board Action

In the event the Board has referred the matter to the Joint Conference Review Committee, the Board, within forty-five (45) days after receipt of the Joint Conference Review Committee's recommendation, shall render its final decision. The Board's action on the matter following receipt of the Joint Conference Review Committee's recommendation, if applicable, shall be immediately effective and final.

C. GENERAL PROVISIONS

1. FURTHER REVIEW

The final decision of the Board following an appeal shall become effective immediately and shall not be subject to further review.

2. RIGHT TO ONE APPEAL ONLY

No Applicant or Medical Staff Member shall be entitled to more than one appellate review on any matter which may be the subject of an appeal. If the Board determines to deny initial Medical Staff appointment to an Applicant, deny granting of Clinical Privileges to an Applicant or Member, or to revoke or terminate the Medical Staff appointment and/or Clinical Privileges of a current Member, the Applicant or Member may not apply for Medical Staff appointment or for those Clinical Privileges at the Hospital for a period of two (2) years unless the Board provides otherwise.

3. WAIVER

If at any time after receipt of a Special Notice of an adverse recommendation, action or result, an Applicant or Member fails to make a required request or appearance or otherwise fails to comply with this Article, he or she shall be deemed to have consented to such adverse recommendation, action or result and to have voluntarily waived all rights to which he or she might otherwise have been entitled under the Bylaws then in effect with respect to the matter involved.

4. SUBSTANTIAL COMPLIANCE

Minor deviations from the procedures set forth in this Article 12 shall not be grounds for invalidating the action taken.

ARTICLE 13 DISPUTE RESOLUTION

A. DISPUTES BETWEEN MEDICAL STAFF AND MEC

In the event of a dispute or conflict between the Medical Staff as a whole and the MEC concerning the adoption, amendment or repeal of these Bylaws or any of the Medical Staff Manuals or policies, and such disputed matter or conflict is not resolved between the President of the Medical Staff and VPMA and representatives of the Medical Staff as a whole, the matter in dispute shall be submitted to the Medical Staff at the next general Medical Staff meeting or special meeting called for such purpose to discuss such disputed Bylaw or Medical Staff Manual provision and to present such matter to the Medical Staff for vote. In lieu of such meeting of the Medical Staff, the matter may be submitted for vote by the Medical Staff utilizing one of the methods described in Article 10, Section B(2). Any such action of the Medical Staff shall be subject to the ultimate approval or adoption by the Board as provided in these Bylaws. A dispute, to be subject to this resolution procedure, must be a matter involving the Bylaws or a Medical Staff Manual or policy and which not fewer than ten percent (10%) of the Active Medical Staff has taken a position (as evidenced by a petition signed by such Members) contrary to the MEC and requested resolution by the Medical Staff pursuant to this Section.

B. DISPUTES BETWEEN MEDICAL STAFF OR MEC AND BOARD

In the event of a dispute or conflict between the Medical Staff as a whole (as evidenced by a petition signed by not fewer than 10% of the Active Medical Staff) and/or the MEC and the Board concerning the adoption, amendment or repeal of these Bylaws or any of the Medical Staff Manuals or policies, such disputed matter or conflict shall be submitted to an ad hoc committee consisting of four (4) members of the MEC appointed by the President of the Medical Staff and VPMA and four (4) members of the Board in joint conference for resolution. Such ad hoc committee shall first meet to discuss the issues as soon as practical in an effort to resolve the matter and obtain information, where appropriate, concerning the conflict or matter in dispute. The decision or action of such ad hoc committee shall be the final decision on such conflict or dispute, except to the extent such matter relates to any matter which pursuant to these Bylaws or state or federal regulation is subject to the ultimate approval or adoption by the Board. In the event such ad hoc committee is unable to resolve such dispute after discussion or the disputed matter when submitted to the ad hoc committee for a vote does not result in resolution by a majority vote of the committee, the committee may engage a mediator to assist in such resolution. In the event such matter remains unresolved, the matter shall be submitted to the Board for ultimate determination. To be subject to this resolution procedure, a dispute must be a matter which the Executive Committee of the Board determines is appropriate for this dispute resolution process or which the Medical Staff as a whole determines to submit to this dispute resolution process, either by an affirmative vote of the Medical Staff at a meeting of the Medical Staff at which such disputed matter was discussed and presented for consideration or by a petition requesting such dispute resolution procedure signed by not fewer than ten percent (10%) of the Active Medical Staff

ARTICLE 14

COMPLETION OF HISTORIES AND PHYSICAL EXAMINATIONS

A valid history and physical examination pertinent to the admitting diagnosis or procedure must be performed or updated and be present in the medical record within 24 hours of admission and in all events prior to any surgical or other diagnostic or therapeutic procedures requiring anesthesia services being instituted. The history and physical examination may only be performed by those healthcare providers authorized by law and for whom Clinical Privileges to do so have been granted by the Board in accordance with the Medical Staff Rules and Regulations and, in the case of nurse practitioners, as authorized by their collaborative practice arrangements. The history and physical examination must be signed by the authorized person taking the history and physical and counter-signed, if required. A valid medical history and physical examination must be completed, documented, and updated within the parameters described in the Medical Staff Rules and Regulations Chapter VII. The specific requirements relating to histories and physicals as they pertain to specific types of patients, setting and type of procedure to be performed, among others, are set forth in the Rules and Regulations, Chapter VII.

ARTICLE 15
GENERAL PROVISIONS

A. CONFLICT OF INTEREST

The Medical Staff values decision-making that is free of conflicts of interest. To be a Member of the Medical Staff, the Member must disclose actual or potential conflicts of interest where those conflicts could affect judgment and decision-making or cause the Member to be biased in his/her decision-making. The Medical Staff delegates to the MEC the authority and responsibility to create the conflict of interest policy and any related documents necessary to implement the policy as well as the authority to determine the appropriate corrective action (up to and including termination of Medical Staff appointment) for failure to comply with the policy.

B. CONFIDENTIALITY OF INFORMATION

Medical Staff, department, section or committee minutes, files and records, including information regarding any Applicant or Member and information of a confidential nature concerning the Hospital, including but not limited to, its operations, strategies and financial condition, shall, to the fullest extent permitted by law, be maintained as confidential.

Dissemination of such information and records shall only be made where expressly required by law, pursuant to officially adopted policies of the MEC, or, where no officially adopted policy exists, only with the express approval of the MEC or its designee or the CEO or his/her designee.

C. BREACH OF CONFIDENTIALITY

Inasmuch as effective peer review and consideration of the qualifications of Medical Staff Members and Applicants to perform specific procedures must be based on free and candid discussions, any breach of confidentiality of the discussions or deliberations of Medical Staff, departments, sections or committees, except in conjunction with other hospitals, professional societies, or licensing authorities, is outside appropriate standards of conduct.

If it is determined that such a breach has occurred, the MEC may undertake such corrective action as it deems appropriate.

D. APPLICANTS' AND MEMBERS' ACCESS TO FILE

1. PRACTITIONER'S ACCESS

An Applicant shall not have the right to review his/her credentialing file, except Applicant is entitled to review and receive a copy of only those documents provided by or addressed personally to the Applicant.

2. MEMBER'S ACCESS

A Member may obtain access to his or her credentials file, subject to the following limitations:

- a. A request for access must be made by the Member to the Medical Staff Office in writing;
- b. The Member may review his/her file in Medical Staff Office during normal working hours, with an officer or designee of the Medical Staff present. The Member may not make copies of the file except for those documents provided by or addressed personally to the Member;
- c. The Hospital reserves the right to limit the amount of information provided to Member if the Hospital determines in its sole discretion that release of the information could be harmful. The Hospital may provide the Member with a written summary of the information but not the source.

E. IMMUNITY FROM LIABILITY

No representative of the Hospital or Medical Staff shall be liable to an Applicant or Member for damages or other relief for any decision, opinion, action, statement or recommendation made within the scope of his/her duties as a representative, if such representative acts after reasonable effort under the circumstances to ascertain the truthfulness of the facts and in the reasonable belief that the decision, opinion, action, statement or recommendation is warranted by such facts.

No representative of the Hospital or Medical Staff and no third party shall be liable to an Applicant or Member for damages or other relief by reason of providing information, including otherwise privileged or confidential information, to a representative of the Hospital or Medical Staff or to any other health care facility or organization of health professionals concerning an Applicant who is or has been an Applicant to or Member of the Medical Staff or who did or does exercise Clinical Privileges or provide specified services at the Hospital, provided that such information is related to the performance of the duties and functions of the recipient of the information.

The confidentiality and immunity provided by this Article applies to all acts, communications, proceedings, interviews, reports, records, minutes, forms, memoranda, statements, recommendations, findings, evaluations, opinions, conclusions or disclosures performed or made in connection with this or any other healthcare facility's or organization's activities concerning, but not limited to:

1. applications for appointment, Clinical Privileges, or specified services;
2. periodic reappraisals for reappointment, Clinical Privileges or specified services;
3. corrective or disciplinary action;
4. hearing and appellate reviews;
5. quality assessment and improvement (peer review) program activities;
6. utilization reviews;

7. claims reviews;
8. profiles and profile analysis;
9. malpractice loss prevention; and
10. other Hospital and Medical Staff activities related to monitoring and maintaining quality and efficient patient care and appropriate professional conduct.

F. RELEASES

Each Applicant or Member shall, upon request of the Medical Staff or Hospital, execute general and specific releases in accordance with the express provisions and general intent of this Article. Execution of such releases shall not be deemed a prerequisite to the effectiveness of this Article.

G. CUMULATIVE EFFECT

The provisions in these Bylaws and in Medical Staff application forms relating to authorizations, confidentiality of information and immunities from liability shall be in addition to all other protections provided by law and not in limitation thereof.

H. INDEMNIFICATION

The Hospital shall provide a legal defense for, and shall indemnify, all Medical Staff officers, department chairs, section chairs, committee chairs, committee members, and authorized representatives when acting in those capacities, to the fullest extent permitted by law, in accordance with the Hospital's Bylaws.

I. DELEGATION OF FUNCTIONS

Unless otherwise set forth herein, when a function is to be carried out by a Medical Staff Member, or by a Medical Staff department, section or committee, the individual, or applicable chair, may delegate performance of the function to one or more qualified designees, subject to approval by the VPMA.

APPENDIX A

May 2012

STANDING AND PERMANENT MEDICAL STAFF COMMITTEES

MEDICAL STAFF COMMITTEES

REPORTING TO

- | | |
|--|-------------------------------|
| 1. Cancer Committee | MEC |
| 2. Clinical Excellence Committee | MEC |
| 3. Credentials Committee | MEC |
| 4. Critical Care Committees –Adults | MEC |
| 5. Documentation Committee | Peer Review Committee/MEC |
| 6. Graduate Medical Education | MEC |
| 7. MEC | Board of Directors |
| 8. NICU Safety Committee | MEC |
| 9. Pediatric Multidisciplinary Committee | MEC |
| 10. Peer Review Committee | MEC |
| 11. Pharmacy and Therapeutics Committee | MEC |
| 12. Radiation Safety | MEC |
| 13. Transfusion Committee | CEC/Peer Review Committee/MEC |
| 14. Trauma Committee | Peer Review Committee |
| 15. Surgical Executive Committee | MEC |
| 16. Vascular Surgery | MEC |

SPECIAL COMMITTEES

- | | |
|-----------------------------------|-------------------------------|
| 1. Continuing Medical Education | MEC |
| 2. Endoscopy | MEC |
| 3. Infection Prevention Committee | Clinical Excellence Committee |
| 4. Nominating Committee | MEC |
| 5. Orthopedic Sub-Committee | Orthopedic Department |

EXHIBIT 2

**IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF MISSOURI
CENTRAL DIVISION**

SPRINGFIELD HEALTHCARE CENTER, INC.,)	
)	
Plaintiff,)	
v.)	
)	
JEREMIAH W. NIXON, ATTORNEY GENERAL OF THE)	Case No.: 05-4296-CV-C-NKL
STATE OF MISSOURI, IN HIS OFFICIAL CAPACITY,)	
AND DARRELL L. MOORE, PROSECUTING)	
ATTORNEY FOR GREENE COUNTY, MISSOURI, IN HIS)	
OFFICIAL CAPACITY,)	
)	
Defendants.)	

STIPULATION OF DISMISSAL

Whereas, for reasons unrelated to this litigation, Plaintiff Springfield Healthcare Center, Inc., has ceased doing business and is no longer providing abortions or other health care services;

The parties hereby agree and stipulate pursuant to Federal Rule of Civil Procedure 41(a)(1)(ii) that this action shall be dismissed without prejudice subject to the following terms:

1. The dismissal shall become effective upon the Court’s dissolution of the Temporary Restraining Order entered on September 16, 2005. By this agreement, all parties respectfully move this Court to sign and enter the proposed Order dissolving the Temporary Restraining Order annexed hereto.
2. All parties shall bear their own costs and fees.

Respectfully submitted this 21st day of October, 2005.

/s/ Janet Crepps

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/s/ Victorine R. Mahon

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/s/ T. Todd Myers

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Assistant Prosecuting Attorney
Darrell L. Moore
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**IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF MISSOURI
CENTRAL DIVISION**

SPRINGFIELD HEALTHCARE CENTER, INC.,)	
)	
Plaintiff,)	
v.)	
)	
JEREMIAH W. NIXON, ATTORNEY GENERAL OF THE)	Case No.: 05-4296-CV-C-NKL
STATE OF MISSOURI, IN HIS OFFICIAL CAPACITY,)	
AND DARRELL L. MOORE, PROSECUTING)	
ATTORNEY FOR GREENE COUNTY, MISSOURI, IN HIS)	
OFFICIAL CAPACITY,)	
)	
Defendants.)	

[PROPOSED] ORDER DISSOVLING TEMPORARY RESTRAINING ORDER

The Court having reviewed and accepted the parties' Stipulation of Dismissal pursuant to Federal Rule of Civil Procedure 41(a)(1)(ii), hereby dissolves the Temporary Restraining Order issued September 16, 2005.

NANETTE K. LAUGHREY
United States District Judge

Dated: _____
Jefferson City, Missouri

CERTIFICATE OF SERVICE

I, Janet Crepps, hereby certify that I electronically filed the foregoing Stipulation of Dismissal and [Proposed] Order Dissolving Temporary Restraining Order with the Clerk of the Court using the CM/ECF system which sent notification of such filing to Victorine R. Mahon, Dustin J. Allison, T. Todd Myers, and Darrell L. Moore.

Dated: October 21, 2005

Respectfully Submitted,

/s/ Janet Crepps
Janet Crepps
Center for Reproductive Rights
2108 Bethel Road
Simpsonville, SC 29681
(864) 962-8519
(864) 962-5928 (fax)

EXHIBIT 3

IN THE UNITED STATES DISTRICT COURT FOR THE
WESTERN DISTRICT OF MISSOURI
CENTRAL DIVISION

COMPREHENSIVE HEALTH OF PLANNED)
PARENTHOOD GREAT PLAINS, et al.)
)
Plaintiffs,)
)
v.) Case No. 2:16-cv-04313-HFS
)
PETER LYSKOWSKI, in his official capacity)
as Director of the Missouri Department of)
Health and Senior Services, et al.)
)
Defendants.)

**REBUTTAL DECLARATION OF STANLEY K. HENSHAW, PH.D. IN SUPPORT OF
PLAINTIFFS' MOTION FOR A PRELIMINARY INJUNCTION**

Stanley K. Henshaw, Ph.D., declares the following:

1. I am an independent consultant working on matters related to reproductive epidemiology, which is the study of the patterns, causes, and effects of behavior related to fertility in defined populations. Until 2013, I was for many years a Senior Fellow with the Guttmacher Institute, an independent nonprofit corporation involved in research, policy analysis, and public education in the field of reproductive health care. I joined the Guttmacher Institute in 1979 and served as its Deputy Director of Research from 1985 to 1999. Over the course of more than thirty years, I have researched and published extensively in the field of reproductive health care. I am the author of numerous studies on the effects of abortion restrictions, and am also familiar with the literature published by others in this area, including literature addressing the effect that an increase in the distance women must travel to obtain abortions has on their ability to obtain abortions. A copy of my *curriculum vitae* is attached hereto as Exhibit A. I submit this declaration as an expert in reproductive epidemiology.

2. I understand from Plaintiffs' counsel that Missouri's Ambulatory Surgical Center Licensing Law, Mo. Ann. Stat. § 197.200 et seq, and its implementing regulations, Mo. Code Regs. Ann. tit. 19 § 30-30.010, 050-070, outline certain requirements for abortion facilities ("ASC Restriction"). I further understand that Missouri law has several separate requirements that physicians who provide abortions must have various forms of hospital admitting privileges and/or a written transfer agreement with a nearby hospital, codified at Mo. Ann. Stat. § 197.215, Mo. Code Regs. Ann. tit. 19, § 30-30.060, Mo. Ann. Stat. § 188.080, and Mo. Ann. Stat. § 188.027(1)(1)(e) (collectively the "Hospital Relationship Restriction"). In addition, I understand that the only health center currently providing generally-available abortion services in Missouri is located in St. Louis, and that there are four additional facilities, located in Kansas City, Columbia, Joplin and Springfield, Missouri, at which Plaintiffs wish to provide abortion services, but are unable to because they cannot comply with the above Restrictions.

3. I have reviewed the declaration submitted by the State Defendants' expert Tumulesh K. S. Solanky. I offer my opinion on certain assertions in that declaration. The fact that I do not address a particular statement or assertion in that declaration does not necessarily mean that I agree with the statement or assertion.

4. Dr. Solanky puts forth an analysis of the average distances women in Missouri have to travel to reach an abortion provider, and the percentage of women who reside within 150 miles of an abortion provider under various scenarios, but Dr. Solanky does not address the demographic and epidemiological literature that clearly demonstrate that increasing the distance women must travel to obtain an abortion decreases the abortion rate, and that increased travel distance is associated with delays in abortion access. Furthermore, Dr. Solanky relies upon incomplete data regarding both the number of abortion providers in Missouri over time and

regarding how the decline in the abortion rate in Missouri compares to the decline in the national abortion rate. For these reasons, Dr. Solanky's opinions cannot be credited.

The Data Do Not Support Dr. Solanky's Conclusions

5. As an initial matter, it is important to note that Dr. Solanky does not purport to have any background in abortion statistics or any experience or expertise understanding the abortion delivery system in the United States. Indeed, his only experience with abortion statistics at all involves serving as a witness in abortion-related litigation. This is a significant impediment to Dr. Solanky's analysis, as he does not seem to understand the way that the availability and location of abortion providers affects women's access to services.

6. For example, Dr. Solanky analyzes the average driving distances to an abortion provider for all women of reproductive age in Missouri under various scenarios, but the nature of the abortion service delivery system makes these sorts of averages unhelpful. For example, as Dr. Solanky points out, women of reproductive age are concentrated near St. Louis, Missouri, where the only current abortion clinic in the state is located. Therefore, calculating averages that include these women does not reveal useful information about how women in other parts of the state are impacted by the lack of providers near their home communities—the average driving distances will be far lower than the distances the affected women actually face. The same is true of Dr. Solanky's calculations regarding the percentage of women of reproductive age in the state who live within a given driving distance of an abortion provider—these kinds of calculations do not provide useful information about the women actually affected by a lack of providers in or near their home communities.

7. Furthermore, Dr. Solanky argues that changes in the availability of abortion providers has not affected women's access to abortion in Missouri, but he relies upon incomplete

data regarding both the number of abortion providers in Missouri over time and the abortion rate in Missouri over time. His conclusions, therefore, cannot be credited.

8. First, Dr. Solanky bases his conclusions on the idea, provided by attorneys for the state, that “the number of abortion facilities in Missouri has changed a number of times during the past 25 years, with some years the number of facilities in Missouri increasing compared to the year before and decreasing for other years.” Decl. of Tulumesh K. S. Solanky, ECF No. 28-4, ¶ 14 (“Solanky Decl”). However, it is misleading to say that the number fluctuated over time when indeed the strong trend was a decline over time. Periodically, the Guttmacher Institute conducts a survey of all known abortion providers in the United States. This survey yields a count of the number of facilities providing abortion services and the number of abortions performed in each state and in the country as a whole. These surveys produce the most complete and accurate information about abortion available. According to the Guttmacher surveys, the number of facilities providing abortions in Missouri has declined gradually over the years, from 15 in 1991 to 2 in 2014, a decrease of 87%.¹ Thus, the data actually show that the number of abortion providers in Missouri has steadily and dramatically declined over the past 25 years.²

¹ These figures includes all abortion providers in the state, including hospitals and doctors’ offices.

² Stanley K. Henshaw and Kathryn Kost, *Trends in the Characteristics of Women Obtaining Abortions, 1974-2004*. Guttmacher Institute (2008) https://www.guttmacher.org/sites/default/files/report_pdf/trendswomenabortions-wtables.pdf (reporting 15 abortion providers in Missouri in 1991); Rachel K. Jones & Jenna Jerman, *Abortion Incidence and Service Availability in the United States, 2014*, 49(1) *Perspectives on Sexual and Reproductive Health* (2017) https://www.guttmacher.org/sites/default/files/article_files/abortion-incidence-us.pdf (reporting 2 abortion providers in Missouri in 2014); *see also* Lawrence B. Finer & Stanley Henshaw, *Abortion Incidence and Services in the United States in 2000*, 35(1) *Perspectives on Sexual and Reproductive Health* 6 (2003) https://www.guttmacher.org/sites/default/files/article_files/3500603.pdf (reporting 10 abortion providers in Missouri in 1996); Rachel K. Jones & Jenna Jerman, *Abortion Incidence and Service Availability in the United States, 2011*, 46(1) *Perspectives on Sexual and Reproductive Health* 3 (2014) <http://online.library.wiley.com/doi/10.1363/46e0414/full> (reporting 6 abortion providers in Missouri in 2008).

9. Similarly, Dr. Solanky is incorrect that the rate of abortions in Missouri has declined at essentially the same pace as the rate of abortions nationally. Solanky ¶ 16. Dr. Solanky relies upon the Centers for Disease Control for the national abortion rate data, but this is not the best available data, since some states, including California, are missing from data compiled by the CDC, and other states do not report complete data to the CDC.³ Far more reliable are data published by the Guttmacher Institute, which show that over the period from 1990 to 2014 the estimated ratio of abortions to births for the United States fell 40.5%.⁴ According to Missouri data relied upon by Dr. Solanky, Solanky Decl. ¶ 16, Ex. C, over that same time period the ratio in Missouri fell 47.5% -- significantly more.

10. The number of abortion facilities is an imperfect indicator of the accessibility of abortion services because many facilities, including most hospitals, perform few abortions and represent accessibility to few women. However, to the extent that the number of facilities is meaningful, a comparison between Missouri and national abortion rate data does not support Dr. Solanky's conclusion that the changes in the number of providers in Missouri has not affected the abortion rate; rather, the data support the conclusions of the research I review below: that increased driving distances to reach an abortion provider (which by definition occurs when providers close) prevent some women who would otherwise have obtained an abortion from doing so. The precipitous drop in abortion facilities in Missouri coincided with a decline in the state's abortion rate greater than in the national rate.

³ See Tara C. Jatlaoui, et al. *Abortion Surveillance – United States, 2013*, 65(12) Morbidity and Mortality Weekly Report 1 (2016) <https://www.cdc.gov/mmwr/volumes/65/ss/ss6512a1.htm>

⁴ See Rachel K. Jones and Kathryn Kooistra, *Abortion incidence and access to services in the United States, 2008*. *Perspectives on Sexual and Reproductive Health* 43(1) 43 (2011); Jones & Jerman, *supra* n. 2. In order to make an appropriate comparison with Dr. Solanky's estimates, the percentage of pregnancies ending in abortion calculated by Guttmacher for each year were converted into ratios of abortions per 1000 live births.

The Effect of Travel Distance on Abortion Rates

11. The best available research shows that increases in the distance women must travel in order to obtain abortions prevent women from having abortions they would have otherwise had. For example, in *Regulating Abortion: Impact on Patients and Providers in Texas*, Silvie Colman and Ted Joyce studied the impact of a Texas law that required that all abortions after 15 weeks' gestation be performed in an ambulatory surgical center ("ASC"). Silvie Colman & Ted Joyce, *Regulating Abortion: Impact on Patients and Providers in Tex.*, 30 J. Pol'y Analysis & Mgmt. 775 (2011). In 2004, when the law went into effect, none of the abortion clinics in Texas qualified as an ASC, which meant that there was an immediate decrease in the availability of abortion after fifteen weeks' gestation in the state. The result of this decreased availability of abortion providers was a significant increase in the average distance that a Texas woman had to travel to obtain an abortion after fifteen weeks' gestation: As the authors reported, the average distance from a woman's county of residence to the nearest county with a non-hospital provider of abortions after fifteen weeks' gestation increased from 33 miles in 2003 to 252 miles in 2004, an increased travel burden of 219 miles.

12. Colman and Joyce concluded that this increase in travel distance had a substantial negative impact on the ability of Texas women to obtain abortions after fifteen weeks' gestation. Examining vital records from Texas and from the health departments of neighboring and nearby states, the authors found that in 2004, the law was associated with a 69% decrease in the number of Texas women who obtained abortions after fifteen weeks, notwithstanding a fourfold increase in the number of Texas women who went out of state for such abortions. In other words, because of the law, many more Texas women traveled out of state to obtain abortions in 2004 than had previously been the case, but despite that fact, there still was a nearly 70% decline in the number

of Texas women having abortions after fifteen weeks in the year the ASC law went into effect. As the study explains, although the Texas law may have encouraged some Texas women to have abortions earlier in pregnancy, this did not offset the reduction in the abortion rate that the increase in travel distance imposed: the study estimated that as a result of the law, over the course of three years, 6,631 abortions did not take place that would otherwise have occurred. In other words, even accounting for women who were able to obtain abortions out of state and women who were able to have earlier abortions, the travel burden imposed by the ASC law prevented thousands of women from obtaining abortions.

13. Similarly, in their study on Georgia abortion rates, Shelton et al. concluded that “the farther a woman has to travel to obtain an abortion, the less likely she is to obtain one.” James D. Shelton, Edward A. Brann & Kenneth F. Schulz, *Abortion Utilization: Does Travel Distance Matter?*, 8 *Fam. Plan. Persps.* 260 (1976). The Shelton study examined abortion rates in Georgia counties at various distances from Atlanta (where all of the major abortion providers in Georgia were located in 1974), and found that for every ten miles of distance from Atlanta, there was a decline of 6.7 abortions per 1,000 live births.

14. In addition, the Shelton study evaluated the impact that reducing the distance women had to travel to obtain abortion care had on abortion rates, and found once again that distance had a substantial impact on abortion rates. Specifically, between 1974 and 1975, two new abortion clinics opened in Georgia—one in Muscogee County and one in Richmond County, each of which is more than 100 miles from Atlanta. From 1974 to 1975, Muscogee County saw a 35% increase in the number of abortions per 1,000 live births, and, significantly, the counties within fifty miles of Muscogee saw a nearly 43% increase. Similarly, from 1974 to 1975, Richmond County had a nearly 47% increase in the number of abortions per live 1,000 live

births, and the counties within fifty miles of Richmond—all of which are more than fifty miles from Atlanta—saw a 40% increase. The findings from the Shelton study show that travel distance, including distances far less than those at issue in the Joyce study, has a substantial effect on abortion access.

15. Other studies of the impact of travel distance on abortion rates have reached comparable conclusions—longer travel distances to access an abortion provider correlate with lower abortion rates. See Robert W. Brown, R. Todd Jewell & Jeffrey J. Rous, *Provider Availability, Race, and Abortion Demand*, 67(3) S. Econ. J. 656 (2001); Sharon A. Dobie, et al., *Abortion Servs. in Rural Wash. St., 1983-1984 to 1993-1994: Availability and Outcomes*, 31(5) Fam. Plan. Persps. 241 (1999). The Brown study of Texas counties found that a doubling of the distance to a county with an abortion provider would be associated with a 23% decline in the abortion ratio for white women, 27% for African-American women, and 50% for Hispanic women. The Dobie study found that due to a decline in the number of providers, abortion services became less available in rural but not urban areas between 1983-1984 and 1993-1994. On average, the distance traveled by rural women for an abortion increased by 12 miles. The abortion rate among rural women declined by 27% and among urban women 17%. Thus, the 12-mile increase in distance caused a 10% fall in abortions among rural women as compared with urban women.⁵

⁵ The Shelton study addresses whether these results can be explained by the possibility that “rural women (who generally live farther away [from abortion providers]) may, in fact, simply desire or need fewer abortions.” James D. Shelton, Edward A. Brann & Kenneth F. Schulz, *Abortion Utilization: Does Travel Distance Matter?*, 8 Fam. Plan. Persps. 260, 262 (1976). As the authors explain, the data do not support this alternative explanation for the effect of distance on abortion incidence: “However, when only rural counties are included, the negative correlation is still strongly apparent. In addition, the opening of two new freestanding clinics in two small urban counties resulted in approximately the same percent increase in use of abortion in the

16. Very recent studies of the effects of abortion restrictions in Texas similar to those at issue in this case also confirm the impact of distance as a barrier to women with unwanted pregnancies. In a 2017 study, Grossman et al. examined the effect of legislation in Texas that resulted in a decline in the number of abortion providers in Texas from 41 in 2012 to 17 in June 2016. Daniel Grossman, et al., Research Letter: Change in Distance to Nearest Facility and Abortion in Texas, 2012 to 2014, 317(4) JAMA 437 (2017). The authors of this study looked at county-level data on abortions received by Texas residents both in and out of state in 2012 and 2014, and analyzed that data based upon the distance of each county to an abortion provider. This study shows that the number of abortions obtained by women in counties where distance to the nearest provider increased by 50-99 miles decreased by 35.7%. The number decreased by 50.3% in counties where the distance increased by 100 or more miles. Taking into account the decrease in abortions in counties that continued to have a facility (15.9%), the increase in distance of 50-99 miles prevented 19.8% of women from having abortions.

17. A prior study by Grossman et al. from 2014 also looked at the effect of these restrictions and the effect, as of the time of the study, of a reduction of the number of abortion providers in Texas from 41 to 22. Daniel Grossman, et al., Change in Abortion Servs. After Implementation of a Restrictive Law in Tex., 90 Contraception 496 (2014). This study found that, prior to the law going into effect, approximately 10,000 women lived more than 200 miles from an abortion provider; after the law went into effect, approximately 290,000 women lived more than 200 miles from an abortion provider. Correspondingly, during the six months after the law took effect, the abortion rate declined by 13% compared with the same six months in the

surrounding *rural* counties as in the urban counties where the clinics operated.” *Id.* (emphasis in original). In other words, the data support the conclusion that it is travel distance, not urban versus rural preferences, that accounts for the impact on abortion incidence.

previous year. Since three-fourths of the state's women who sought abortions in 2011 resided in the four largest metropolitan areas, each of which continued to have three or more abortion facilities, the decline would have been much greater than 13% in the other areas of the state. In these areas of the state, the number of providers declined from 11 to 2. In the Lower Rio Grande Valley, where the only two clinics closed, the number of abortions declined 21%.

18. Considering the results of these studies, I estimate that, in general, an additional travel burden of 100 miles will cause 20 to 25% of women who would have otherwise obtained abortions not to obtain them. Greater distances will be a barrier to an even higher percentage of women.

19. In addition to women who are prevented from obtaining an abortion because of increased travel distances, the research shows that, for women who are ultimately able to obtain an abortion, the financial and logistical difficulty associated with increased travel distances causes women to delay obtaining an abortion. This problem is particularly acute for low-income women. *See generally* Decl. of Sheila M. Katz in Supp. of Pls.' Mot. for Prelim. Inj., ECF No. 15-5.

20. Indeed, the 2014 Grossman study that looked at the effect of the reduction in the number of abortion providers in Texas from 41 to 22 found that statewide there was a statistically significant increase in the proportion of abortions that occurred in the second trimester.

21. Multiple studies have shown that women who experience delays in obtaining abortions frequently cite among the factors that caused the delay (1) acquiring the funds to pay for the procedure, and (2) overcoming transportation-related hurdles. For example, in a 2006 sample of 1,209 abortion patients in 11 clinics, among those who said that they would have

preferred to have had their abortions earlier, 26% said they were delayed by the time needed to acquire the money needed to have the abortion, and 7% were delayed because there was no nearby clinic and they had to arrange transportation. Lawrence B. Finer, et al., *Timing of Steps and Reasons for Delays in Obtaining Abortions in the United States*, 74 *Contraception* 334 (2006).

22. Similarly, a survey of women who had abortions at 30 clinics selected to represent all clinics nationally showed that, of women who had abortions at or after 16 weeks and experienced delay, 28% reported that a reason for the delay was the time they needed to obtain money to pay for the abortion, and 12% reported that a reason was that they had to arrange transportation because there was no nearby provider. Aida Torres & Jacqueline Darroch Forrest, *Why Do Women Have Abortions?*, 20(4) *Fam. Plan. Persps.* 169 (1988).

23. Moreover, the Finer and Torres studies make clear that “[l]ower-income women are . . . more likely to have later abortions,” Finer, *supra*, at 335, and that for women who seek abortions in the second trimester but who would have preferred to have had earlier abortions, the burdens of raising money for the procedure and making travel arrangements to access the clinic played an especially significant role in causing delay. In the Finer study, of second-trimester patients who experienced unwanted delay, 36% attributed the delay to the need to raise money; 16% were delayed because they had difficulty finding out where to get an abortion; and 9% were delayed by the need to obtain transportation to a non-local provider. The Torres study found that of women seeking abortions at sixteen weeks or later who experienced delay, nearly half attributed the delay to difficulties in making arrangements for the abortion—difficulties that included the time necessary to raise money, challenges in arranging for transportation, trouble finding out where to obtain an abortion, and difficulty in arranging for child care.

24. It is also important to recognize that the Finer and Torres studies reviewed above necessarily capture only those women who were ultimately able to obtain abortions. For many women, however, increasing the travel and financial burdens associated with obtaining an abortion can impose an insurmountable barrier, as the other studies discussed above indicate.

Application of this Research to the Present Case

25. As the preceding discussion explains, research shows that an increase in the distance women must travel to access an abortion leads to a decrease in the abortion rate. When women are forced to travel longer distances to obtain an abortion, some women are unable to do so—that is, some women who would otherwise have terminated their pregnancies are prevented from doing so. And of the women who are able to travel to a non-local provider, longer travel distances (and the increased cost associated with them) lead to delayed access to abortions, especially for low-income women. Given the distances Missouri women must currently travel in order to reach an abortion provider, this research indicates that some Missouri women are currently being prevented from accessing an abortion and others are being delayed.

26. As set forth above, I understand that there is currently only one facility providing generally-available abortion services in the state of Missouri, in St. Louis, and that there are four additional health centers in Missouri, in Columbia, Springfield, Joplin, and Kansas City, at which Plaintiffs would provide abortions but for the Restrictions. Women in the Columbia area face an increased travel distance of approximately 122 miles one-way in order to reach the abortion provider in St. Louis rather than one in their own community. Women in Springfield face an increased distance of approximately 214 miles one-way, and women in Joplin face an increased distance of approximately 281 miles one-way. The reviewed research above shows that increases in travel distances of these magnitudes prevent at least 20-25% of these affected women from

obtaining an abortion. The research further shows that even for women who are able to overcome these increased distances and travel to an abortion clinic, many are likely to experience unwanted delay.

27. Traveling out of state does not alleviate these burdens for many women either. Columbia, Missouri is approximately 135 miles from the closest out of state abortion provider in Overland Park, Kansas. Springfield, MO is approximately 135 miles from the closest out of state abortion provider in Fayetteville, Arkansas, and Joplin, Missouri is approximately 86.6 miles to Fayetteville, Arkansas. Importantly, the health center in Fayetteville, Arkansas offers only medication abortion up to 9 weeks of pregnancy.⁶ Therefore, in order for women in the Springfield area to access the surgical abortion services that would be available in their home community but for the Restrictions, they would have to travel even further —160 miles—to the next closest out-of-state provider in Overland Park, Kansas.⁷ The reviewed research above suggests that for women in Columbia and Springfield, the travel distances required for them to reach an out of state provider will prevent at least 20-25% of affected women from obtaining an abortion, and will delay still others, which may increase the cost associated with obtaining an abortion and will increase the risk to their health. For affected women in the Joplin area, the research suggests that 15-20% will be prevented from obtaining an abortion and still others will be delayed.

⁶ Planned Parenthood Great Plains, Abortion Servs. in Fayetteville, AR – Get the Pill, Facts & Cost (2017) <https://www.plannedparenthood.org/health-center/arkansas/fayetteville/72703/fayetteville-health-center-2972-90740/abortion>.

⁷ Planned Parenthood Great Plains, Abortion Servs. in Overland Park, KS – Get the Pill, Facts & Cost (2017) <https://www.plannedparenthood.org/health-center/kansas/overland-park/66211/comprehensive-health-center-2594-90740/abortion>.

Conclusion

28. In summary, it is my opinion that the fact that there is currently only one abortion facility in Missouri providing generally-available abortion services, to which all women in the state must travel to obtain an in-state abortion, is preventing a substantial proportion of women who would have obtained an abortion from doing so, and is causing many of the women who are ultimately able to access an abortion provider to experience unwanted delay. This conclusion is supported by the best available research regarding the effect of driving distances on abortion access, and Dr. Solanky's report does not undermine this research.

I declare under penalty of perjury that the foregoing is true and correct.

Dated: January 31, 2017

s/ Stanley K. Henshaw
Stanley K. Henshaw

EXHIBIT A

Curriculum Vitae

7/16

STANLEY K. HENSHAW

24 Yancey
1082 Fearington Post
Pittsboro, NC 27312
(919)542-0878

Education

Ph.D. Columbia University, Department of Sociology, 1971.

A.B. Harvard College, 1960. Field of concentration, physics.

Professional Experience

2000 - present: Consultant for various nonprofit organizations on research concerning fertility control services and behavior.

2000 - 2013: Senior Fellow, Guttmacher Institute, New York, New York (part-time consultant). Report writing and advising on research regarding abortion and family planning services.

1979 - 1985: Senior Research Associate, and 1985 - 1999: Deputy Director of Research, The Alan Guttmacher Institute. General duties include proposal writing, design, supervision of data collection, analysis and report writing for research projects on fertility-related issues. Responsible for overseeing a periodic survey of all abortion providers in the United States.

1978 - 1979: Senior Analyst, Zanes & Assoc. Inc., a marketing research firm in Fort Lee, New Jersey. Responsibilities included supervising two project directors, overseeing all phases of survey research projects (sampling, questionnaire construction, data collection and validation, data processing, analysis, and report writing), and report writing for focus group interviews.

1977 - 1978: Senior Analyst, Roger Seasonwein Associates, New Rochelle, New York. Responsibilities were concentrated in the following areas of public opinion research: questionnaire construction, survey data analysis using multivariate and other statistical methods, report writing, and statistical programming.

1976 - 1978: Coadjutant, Rutgers University, teaching statistics in the nursing master's degree program, and consulting on various survey research projects.

1971 - 1976: Research Associate, Cornell University Medical College, Department of Public Health. Evaluated the PRIMEX Family Nurse Practitioner Project using survey research and experimental techniques. Also conducted an evaluation of a continuing education program for physicians and nurses.

STANLEY K. HENSHAW

1971 - 1975: Survey research consultant on various projects, including a study of alcoholism programs conducted by the National Study Service, a study of hospital administrators by the Alumni Association of the Columbia University School of Public Health, and others.

1969 - 1971: Research Associate, Columbia University School of Public Health. Conducted a study of consumer reactions to automated multiphasic health screening. The research involved personal interviews with 1,300 users and potential users of a free health testing program to identify factors related to acceptance and utilization of the program.

1967 - 1968: Consultant on the evaluation of an experimental rehabilitation program for skid-row alcoholics administered by the Community Council of Greater New York.

1965 - 1967: Senior Research Assistant, Bureau of Applied Social Research, Columbia University, on the "Homelessness Project," a study of skid-row alcoholics.

Professional Activities

Reviewer for the *American Journal of Epidemiology*, *American Journal of Obstetrics and Gynecology*, *American Journal of Preventive Medicine*, *American Journal of Public Health*, *American Psychologist*, *BMC Public Health*, *Contraception*, *Demography*, *Health Reports* (published by Statistics Canada), *The Journal of Rural Health*, *Journal of Policy Analysis and Management*, *Journal of the American Medical Association*, *Journal of the American Medical Women's Association*, *Obstetrics & Gynecology*, *Paediatric and Perinatal Epidemiology*, *Perspectives on Sexual and Reproductive Health*, *Psychological Medicine*, *Public Health Reports*, *Social Science & Medicine*, *Social Science Quarterly*, *Studies in Family Planning*, and *Women's Reproductive Health*.

Member, Board of Directors, Abortion Access Project (Cambridge, MA), 2005 to 2011.

Member, Board of Directors, National Abortion Federation, 1989 to 1995.

Associate Editor, *Health and Society: The Milbank Memorial Fund Quarterly*, December, 1973 to June, 1976.

Memberships:

- American Public Health Association
- International Union for the Scientific Study of Population
- Population Association of America
- Society of Family Planning

Honors:

2015 Lifetime Achievement Award, Society of Family Planning, 2015

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Felicia Stewart Advocacy Award, American Public Health Association, Population, Reproduction, and Sexual Health Section, 2015
Alan Guttmacher Lectureship, Association of Reproductive Health Professionals, 2008
Carl S. Shultz Award in Recognition of Outstanding Contributions to the Field of Family Planning and Reproductive Health, American Public Health Association, Population, Family Planning and Reproductive Health Section, 2006
Champion of Reproductive Health, Ipas (Chapel Hill, NC), 2004
Christopher Tietze Humanitarian Award, National Abortion Federation (Washington, DC), 2000
Outstanding Scientific Contribution, National Family Planning and Reproductive Health Association (Washington, DC), 2000
Best Clinical Paper, National Abortion Federation (Washington, DC), 1986

Expert witness in numerous federal and state legal proceedings concerning abortion and adolescent sexual behavior.

Publications

Kathryn Kost and Stanley Henshaw: *U.S. Teenage Pregnancies, Births and Abortions, 2010: National and State Trends by Age, Race and Ethnicity*. New York: Guttmacher Institute, May, 2014 (<http://www.guttmacher.org/pubs/USTPTrends10.pdf>).

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Stephanie J. Ventura, Joyce C. Abma, William D. Mosher and Stanley K. Henshaw: "Estimated Pregnancy Rates for the United States, 1990-2005: An Update." *National Vital Statistics Reports*, Vol. 58, No. 4, 2009.

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“The Impact of Religion on Abortion Practice,” presented at the seventh congress of the International Federation of Abortion and Contraception Professionals, Rome, Italy, October 13, 2006.

“Characteristics of Women Seeking Abortion Services and Post-Abortion Care in Nigerian Hospitals,” with I.F. Adewole, S. Singh, A. Bankole, B.A. Oye-Adeniran, R. Hussain and G. Sedgh, presented at the 25th International Population Conference, International Union for the Scientific Study of Population, Tours, France, July 23, 2005.

“Abortion Fees: Trends and Correlates,” poster session at the annual meeting of the National Abortion Federation, Seattle, April, 2003.

“Lifetime Incidence of Abortion and Trends in Repeat Abortion,” with Rachel K. Jones and Jacqueline E. Darroch, presented at the annual meeting of the National Abortion Federation, Seattle, April, 2003.

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“Mifepristone Use for Early Abortion in France, Great Britain and Sweden,” with Rachel Jones, presented at the annual meeting of the National Abortion Federation, San Jose, April, 2002.

“Trends in the Characteristics of Women Having Abortions,” presented at the annual meeting of the National Abortion Federation, Chicago, April 23, 2001.

“U.S. Abortion Statistics: Shortcomings and a Proposal for Improvement,” presented at the annual meeting of the American Public Health Association, Boston, November 14, 2000.

“Global Abortion Laws and Access,” presented at *Abortion in Focus*, conference organized by the Abortion Providers’ Federation of Australasia, Coolumb, Queensland, Australia, November 12, 1999.

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"Trends in Teen Pregnancy, Birth, and Abortion: United States," presented at the annual meeting of the Association of Reproductive Health Professionals, Dallas, September 23, 1999.

"Induced Abortion: International Trends and a Nigerian Case Study," presented at the Population Council, New York, November 10, 1998.

"The Completeness of Abortion Statistics," presented at the Meeting to Discuss Data Needs for Evaluating Welfare Reform sponsored by the University of Maryland School of Public Affairs and the American Enterprise Institute, Washington, May 28, 1998.

"World Overview of Abortion," presented at the annual meeting of the National Abortion Federation, Vancouver, May 19, 1998.

"Measuring the Extent of Underreporting in the 1995 National Survey of Family Growth," with Haishan Fu, Jacqueline E. Darroch and Elizabeth Kolb, poster session at the annual meeting of the Population Association of America, Chicago, April 2, 1998.

"Characteristics Associated with Abortion Utilization, 1994 and 1987," presented at the annual meeting of the National Abortion Federation, San Francisco, April 1, 1996.

"Abortion Laws and Practice Worldwide," presented at Abortion Matters: International Conference on Reducing the Need and Improving the Quality of Abortion Services, Amsterdam, The Netherlands, March 28, 1996.

"Abortion: A World Overview," presented at the annual meeting of the Nordic Network on Abortion Epidemiology, Lillehammer, Norway, February 9, 1995.

"How Safe is Therapeutic Abortion?" presented at the 13th World Congress of Gynaecology and Obstetrics, Singapore, September, 1991.

"Collecting and Interpreting Data on Unintended Pregnancies," presented at the Planned Parenthood Southern Region Spring Conference, Jacksonville, May 2, 1991.

"Worldwide Patterns of Abortion Incidence," presented at *From Abortion to Contraception: Public Health Approaches to Reducing Unwanted Pregnancy and Abortion Through Improved Family Planning Services*, conference organized by WHO Regional Office for Europe, Tbilisi, USSR, October, 1990.

"Physician Shortage in Abortion Practice: Statistical Overview," presented at the Physician Recruitment Symposium organized by the National Abortion Federation, Santa Barbara, October, 1990.

"Problems in Access to Abortion Services," presented at the American Public Health Association 118th Annual Meeting, New York, October, 1990.

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"Metropolitan Areas with Inadequate Abortion Service Provision," presented at the annual meeting of the National Abortion Federation, Atlanta, May, 1990.

"Monitoring Potential Changes: AGI Studies of Abortion Service Provision," presented at the Psycho-Social Workshop, Toronto, May, 1990.

"Estimating the Incidence of Abortion from Repeat Abortion Histories," presented at the annual meeting of the Population Association of America, Toronto, May, 1990.

"Current Facts and Figures from The Alan Guttmacher Institute," presented at the American Public Health Association 117th Annual Meeting, Chicago, October, 1989.

"Abortion Rates by Religion, Income and Hispanic Origin: New National Data," with Jane Silverman, presented at the American Public Health Association 115th Annual Meeting, New Orleans, October, 1987.

"Prior Contraceptive Use among Abortion Patients: Preliminary Results from a National Study," with Jane Silverman, presented at the American Public Health Association 115th Annual Meeting, New Orleans, October, 1987.

"Recent Trends and Future Projections for Clinic Abortion Services," presented at the annual meeting of the National Abortion Federation, Salt Lake City, May, 1987.

"Sorting Out the Confusions in Adolescent Pregnancy Statistics," presented at the conference of the Association of Population Libraries and Information Centers, Chicago, April, 1987.

"Overview of World Situation Regarding Abortion," Population Seminar sponsored by the United Nations Population Division, New York, February, 1987.

"U.S. Abortion Laws and Policies in International Perspective," presented at the annual meeting of the American Public Health Association, Las Vegas, October, 1986.

"U.S. Abortion Rates and Trends in International Perspective," presented at the annual meeting of the American Public Health Association, Washington, D.C., November, 1985.

"Reasons for Variation in Teenage Childbearing among the States," with Susheela Singh, presented at the annual meeting of the American Public Health Association, Washington, D.C., November, 1985.

"The Number and Characteristics of Office-Based Physicians Who Performed Abortions in the U.S. in 1982," with Margaret Terry Orr, presented at the annual meeting of the American Public Health Association, Anaheim, California, November, 1984.

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"Abortion Services Provided in Physicians' Offices," presented at the annual meeting of the National Abortion Federation, Los Angeles, May, 1984.

"The Availability of Abortion Services Since 1973," presented at the annual meeting of the American Public Health Association, Dallas, November, 1983.

"Future Trends in Demand for Abortion Services," presented at the annual meeting of the National Abortion Federation, New Orleans, April, 1983.

"Number of Women at Risk of Unintended Pregnancy: Estimates for 1980 in Comparison with 1979 Estimates," with Jacqueline Darroch Forrest, paper presented at the annual meeting of the National Family Planning and Reproductive Health Association, Washington, D.C., March, 1983.

"A Study of the Experience of Medicaid Recipients in Paying for Abortions in States where Medicaid-Financed Abortions are Restricted," presented at the annual meeting of the American Public Health Association, Montreal, Canada, November, 1982.

"The Public's View of the Morality of Abortion," presented at the National Abortion Federation annual meeting, Minneapolis, May, 1982.

"An Investigation into the Reasons for Increases in the U.S. Abortion Rate," poster session, annual meeting of the American Public Health Association, Los Angeles, November, 1981.