MEDICAL STAFF

BYLAWS

June 2024

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SHANDS JACKSONVILLE MEDICAL STAFF BYLAWS

Bylaws are adopted to provide a structure for self-governance for the organized Medical Staff of the Hospital. The Bylaws provide the framework for the Medical Staff to discharge its responsibility in matters involving the quality of patient care, treatment and services; at all times the Medical Staff shall remain accountable for such to the Board of Directors of Shands Jacksonville Medical Center, Inc. The Bylaws articulate processes for the orderly conduct of Medical Staff functions and resolution of issues.

DEFINITIONS

1. **Advanced Practice Professional or APP**: a licensed healthcare professional who is granted clinical privileges by the Board but is not a member of the Medical S 0 Td[r)9Td3(ar)-2 (d)12.sd2[af

12. **Medical Record:** Hospital approved repository, electronic or otherwise, used to track and record patient medical information regarding services and treatments provided at the Hospital.

13. **Medical Staff:** the organized structure of medical and osteopathic physicians, dentists, and podiatrists who have met the requirements of the Medical Staff Bylaws and who have received an appointment to the Medical Staff by the Board.

14. **Medical Staff Governing Documents or MSGD**: the Medical Staff Bylaws, the Policy on Clinical Privileges-Advanced Practice Professionals, the Medical Staff Policies, and the Medical Staff Rules and Regulations (if any), as and how such documents may from time to time be promulgated, revised or amended as herein provided. These documents are intended to be read together, with the provisions of the Bylaws enhanced by the particular details contained in other MSGDs. In the event of a conflict between the Bylaws and any other MSGD the Bylaws shall prevail.

15. **Nominating Committee**: a committee that consists of the President, the Vice President, the CEO or designee, the Dean of the University of Florida College of Medicine – Jacksonville, and the CMO.

16. **Notice**: Unless otherwise specifically provided for in these Bylaws. "Notice" shall mean, and be deemed given when: (a) a written communication is personally delivered to the addressee's business office or home and placed in the hands of the named addressee or his/her assistant or other person in the addressee's office or home who routinely accepts mail on behalf of the addressee, or (b) a written communication is deposited with the U.S. Postal Service (USPS) for any type of delivery service then offered by USPS or other commercial express delivery service, or (c) information addressed to the addressee is transmitted by facsimile or e-mail to the addressee's fax or e-mail address.

17. **Ongoing Professional Practice Evaluation or OPPE**: Ongoing Professional Practice Evaluation is a process whereby the Hospital identifies professional practice trends that may impact quality of care and patient safety which may require formal or informal intervention by the Chief of Service or other Medical Staff leadership, including but not limited to a structured plan for improvement

18. **Physician:**

25. **UFHSC/J:** the University of Florida Health Science Center/*Jacksonville*.

26. **Vice President of the Medical Staff or Vice President:** the physician who is appointed to assist the President in performing their duties.

ARTICLE I. MEDICAL STAFF MEMBERSHIP

SECTION 1. NATURE OF MEDICAL STAFF MEMBERSHIP

Membership on the Medical Staff 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, (expressly including but not limited to the Minimum Required Qualifications in Section 2 below), associated policies, rules and regulations of the Medical Staff and the Hospital.

SECTION 2. MINIMUM REQUIRED QUALIFICATIONS FOR MEMBERSHIP

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c. The applicant has qualification/experience equivalent to Board Certification by the specialty and/or subspecialty board applicable to the grant of privileges sought as based on recommendation of the Chief of Service.

    i. The Medical Staff Services Office may only provide an application for membership to a physician who is recommended by the Chief of Service as having equivalent qualification/experience if the grant of membership to the physician would not cause the applicable Service to exceed 10% (rounded down to the nearest whole number) who have not qualified under 10.a. or 10.b. above unless the Service has fewer than 10 members, in which case there may be one such member for the Service.

    ii. If the Service has reached its 10% threshold, the applicable Chief of Service must provide written documentation to the MEC demonstrating that the physician has equivalent qualifications/experience and either meets a critical care need or possesses unique professional qualifications. The MEC may approve the release of the application to such physician only if the President of the Medical Staff votes in the majority to approve such release,
    or

d. Practitioners appointed to the Medical Staff prior to September 1, 1999 who were not, at that time, Board Certified are exempt from this requirement, or

e. Applicants applying for privileges exclusively in general dentistry do not need to hold Board Certification.

Once Board Certification is obtained or Chief of Service determines equivalent qualification/experience it must be continuously maintained.593 Tw4.6 (9d.593 T (i)-2.6 (d)2 (en)(C)3.9 (m)1

SECTION 3. NON-DISCRIMINATION.

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C. This Article does not pertain to issues involving disciplinary action, denial of requests for appointment or clinical privileges or any other matter relating to an individual Practitioner's Membership or privileging action. The fair hearing procedures in accordance with Article XII provide detailed recourse in these matters.

ARTICLE II. CATEGORIES OF THE MEDICAL STAFF

SECTION 1.

SECTION 3. QUALIFICATIONS

The President and the Vice President must be a member in good standing of the Active Category, have previously actively served on a Medical Staff or a Hospital committee or as a Service Chief, indicate a willingness and ability to serve, be knowledgeable of the Medical Staff Governing Documents as well as regulatory aspects of Medical Affairs, and have demonstrated excellent leadership, collaboration, problem-solving, administrative, and communication skills. The President and the Vice President may not be from the same Service, and neither the President nor the Vice President may be from the same Service as the Immediate Past President. The President may not serve as the Chair of any Medical Staff Committee other than the MEC. Officers may not simultaneously hold a leadership position with another hospital's medical staff. Failure to maintain such qualifications during the term in office shall immediately create a vacancy in the office involved.

SECTION 4. TERM OF OFFICE

The term of office for Officers shall be two (2) years. Officers assume office on July 1 following their appointment, except that an Officer appointed to fill a vacancy assumes office immediately upon appointment. Each Officer serves until the end of the term or until a successor is appointed, unless the Officer is removed from office.

SECTION 5. VACANCY IN OFFICE

If a vacancy occurs in the office of the President, the Vice President shall serve out the remainder of the President's term. If a vacancy occurs in the office of Vice President, the office shall be filled in the same manner as provided in these Bylaws. If a vacancy occurs in the office of Immediate Past President, the office shall remain vacant until it is filled upon the natural expiration of the current President's term as provided herein. If both the offices of President and Vice President are vacant, the office of President shall be filled in the same manner as provided in these Bylaws for filling the office of Vice President.

SECTION 6. DELEGATION OF FUNCTIONS

When an Officer or other individual assigned a function under these Bylaws is unavailable or unable to perform a necessary function, one or more Officers or the Chief Medical Officer may perform the function in the following order of precedence based on availability: President, Vice President, Immediate Past President, and Chief Medical Officer. If none of the Officers or the Chief Medical Officer is available or able to perform the necessary function, any of the Officers or the Chief Medical Officer may delegate it to another appropriate individual. Any such designee is bound by all terms, conditions, and requirements of the Medical Staff Governing Documents. The delegating individual is responsible for ensuring that the designee appropriately performs the function in question.

SECTION 7. DUTIES OF OFFICERS AND CHIEF MEDICAL OFFICER

A. The President shall:

1. Represent and communicate the views, policies, and needs – and report on the activities of – the Medical Staff to the CEO and the Board;
2. Serve as the liaison between the Medical Staff and Hospital Administration and between the Medical Staff and the Board in all matters of mutual concern involving patient care;
3. Call, preside at, and be responsible for the agenda of all general meetings of the Medical Staff;
4. Serve as Chair of the MEC;
5. Appoint the members and chairs of Medical Staff committees, unless otherwise specified in the Medical Staff Governing Documents;
6. Take administrative actions for the MEC, when necessary, between meetings;
7. Promote adherence to the bylaws, policies, and rules and regulations of the Hospital and its Medical Staff;
8. Oversee Medical Staff clinical activities, including quality improvement and patient safety;
9. Report to the CEO and the Board regarding clinical performance of the Medical Staff and quality improvement and patient safety;
10. Represent the Medical Staff at Hospital Board of Directors meetings, to outside licensing and accreditation agencies, and to the public;
11. Serve as a liaison to the University of Florida College of Medicine – Jacksonssse qua 41(n)12.9 (e)]TJ0 Tc

SECTION 8.

A. Receive and act upon reports and recommendations from the Medical Staff committees, Services, and other assigned activity groups of the Medical Staff concerning patient care quality and appropriateness reviews, evaluation and monitoring functions, and the discharge of delegated administrative responsibilities, and recommend to the Board specific programs and systems to fulfill these functions;

B. Receive and act upon reports, if appropriate, from the University of Florida College of Medicine – Jacksonville Graduate Medical Education Committee regarding the safety and quality of patient care, treatment, and services provided by related educational and supervisory needs of Residents participating in graduate medical education programs;

C. Coordinate the activities of, and implement the policies adopted by Services, Medical Staff, and the Hospital;

D. Submit recommendations to the Board concerning all matters relating to appointments, reappointments, staff category, and clinical privileges;

E. Encourage professionally ethical conduct and competent clinical performance on the part of staff appointees, including initiating investigations and initiating corrective action, when appropriate;

F. Account to the Board and to the staff for overall quality and efficiency of patient care in the Hospital and the participation of the Medical Staff in organization performance improvement activities;

G. Make recommendations to the Board regarding medico-

SECTION 3. PERFORMANCE IMPROVEMENT COMMITTEE

Composition: The membership of the Performance Improvement Committee shall include no fewer than eight (8) representatives of the Active Medical Staff, including at least two (2) members each of the Medicine and Surgery Services. The Committee may also include a Resident and representatives from Hospital administration, including but not limited to nursing services, human resources, and risk management. The Committee Chair shall have the authority to invite such additional persons from time to time as are beneficial to address the issues before the Committee.

Duties: The duties of the Performance Improvement Committee shall be to monitor compliance with and enforce the Medical Staff rules and regulations and Medical Staff policies, and to assist the MEC in the performance of its assigned responsibilities. In addition, the Performance Improvement Committee shall:

A. Ensure that when the performance of a process is dependent primarily on the activities of one or more Provider, the Committee provides leadership for the process measurement, assessment, and improvement. These processes include, but are not limited to:

   1. Medical assessment and treatment of patients;
   2. Use of medications;
   3. Use of blood and blood components;
   4. Use of operative and other procedure(s);
   5. Efficiency of clinical practice patterns; and
   6. Significant departures from established patterns of clinical practice.

B. Ensure that the Medical Staff participates in the measurement, assessment, and improvement of other patient care processes. The processes include but are not limited to:

   1. Education of patients and families;
   2. Coordination of care with other Providers and hospital personnel, as relevant to the care of an individual patient; and
   3. Accurate, timely, and legible completion of patients' medical records.

C. Ensure that when the findings of the assessment process are relevant to an individual's performance, the Committee is responsible for determining appropriate use in accordance with standards and regulations.

D. Ensure that the findings, conclusions, recommendations, and actions taken to improve

The composition and duties of any other Medical Staff Committees shall be as stated in the Medical Staff Governing Documents and approved by MEC.

ARTICLE VI. SERVICES AND DIVISIONS

investigating clinical performance and conducting and initiating any corrective action required.

F. Be responsible for enforcement within the Service of the Hospital and Medical Staff bylaws, rules and regulations, and policies.

G. Work with the Hospital administration with regard to all administrative matters, patient care issues, and nursing care issues related to the Service.

H. Supply references required by other institutions or organizations for credentialing purposes.

I. Assess and recommend to the MEC or the Board off-site sources for needed patient care, treatment, and services that are not provided by the Service or the Hospital.

J. Be responsible for the integration of the Service into the primary functions of the Hospital and for the coordination and integration of inter-service and intra-service services.

K. Develop and implement policies and procedures that guide and support the provision of care, treatment, and services.

L. When appropriate, make recommendations concerning a sufficient number of qualified and competent persons to provide care, treatment, and services.

M. Help provide for the orientation and education for all persons in the Service relative to Service issues.

N. Recommend to the CEO or a designee, space and other resources needed by the Service.

O. Make recommendations regarding the oversight and maintenance of quality control programs, as appropriate.

P. Make recommendations to the Credentials Committee, Medical Executive Committee and Hospital administration concerning any proposed new procedures and services, including the training, education and experience required for Providers to exercise privileges for new procedures or services.

Q. Be responsible for assuming compliance with Hospital regulatory agencies.

ARTICLE VII. RESIDENTS

Residents: It is the policy of the Medical Staff to assist with approved graduate education programs.

Qualifications: Physicians, dentists, and podiatrists in a post-graduate training program sponsored by the Hospital or the University of Florida College of Medicine-Jacksonville (hereinafter referred to as a "Training Program") shall be referred to in these Medical Staff Bylaws as "Residents". Residents are not members of the Medical Staff nor do they receive a grant of privileges; accordingly, they are not subject to the Medical Staff credentialing privileges. An individual's status as a Resident shall commence with the appointment to a Training Program and will conclude with termination from the Training Program.

Responsibilities: Residents shall:

Annual Medical Staff Meetings: The presence of thirty (30) Active Medical Staff members shall constitute a quorum.

Medical Executive Committee Meetings: The presence of fifty percent (50%) of the members of the committee eligible to vote shall constitute a quorum.

Credentials Committee Meetings: The presence of one third (1/3) of Committee members eligible to vote shall constitute a quorum.

All Other Medical Staff or Committee Meetings: The Committee Chair shatredtB Tw 0 -2.033 TD.6 4c C-TAcallesee(T

SECTION 6. ACTION AT MEETINGS

The recommendation of a majority of its members present at a meeting at which a quorum is present shall be the action of a committee unless otherwise stated in Medical Staff Governing Documents. Such recommendation will then be forwarded to the MEC for action as appropriate.

SECTION 7. MINUTES

Minutes of committee meetings shall be made, recording the attendance of members and other persons present, and the result of each matter presented for a vote. The Committee Chair or person presiding over the meeting shall sign the minutes. Each committee shall maintain minutes of committee meetings.

SECTION 8. PARTICIPATION BY HOSPITAL CHIEF EXECUTIVE OFFICER

The CEO or his/her designee may attend any committee meeting of the Medical Staff.

ARTICLE X. HOSPITAL INDEMNIFICATION OF MEDICAL STAFF MEMBERS

The Hospital will defend and indemnify a Medical Staff member for claims arising out of his/her good faith performance of his/her duties as a member of a Medical Staff committee or his/her participation in Medical Staff or Hospital peer review and/or quality assurance/improvement activities.

ARTICLE XI. APPOINTMENT AND CLINICAL PRIVILEGES

PART A: CONDITIONS AND DURATION

Medical Staff appointment or reappointment shall not confer any clinical privileges or right to practice in or admit patients to the Hospital. Each individual who has been given an appointment to the Medical Staff shall be entitled to exercise only those clinical privileges specifically granted by the Board, subject to the Hospital's right to contractually arrange with a group or entity for the exclusive furnishing of certain services at the Hospital.

The clinical privileges recommended to the Board shall be based upon the applicant's education, training, experience, demonstrated current competence and ability to perform those privileges requested, the ability to assure qualified medical coverage in the Practitioner's absence, the availability of Hospital resources and personnel to support the privilege (t)-ivyonnei.9 (c)-t (e (t)-i)6.3 (dc -0.002 10.9 (oi)d 9 (t)-4..2 (xc)-1(ur)-4 (ni)6.3 (he)-1

B. Appointments and reappointments to the Medical Staff shall be for no more than three (3) years and may be shorter.

PART B: APPLICATION PROCESS

SECTION 1. APPLICATION

A. An application for appointment, reappointment, clinical privileges, or change in Medical Staff category or status ("application") shall be submitted in writing and shall include detailed information concerning the applicant's professional qualifications.

B. A preliminary screening process shall be implemented to ascertain whether an applicant meets the

application, including acknowledgement that, in the event that approval has been granted prior to

applicant, the recommendation shall be forwarded to the Board for final action. All recommendations to approve appointment and/or grant privileges must also recommend the

training and experience that justify such modification. The request shall be processed in the same manner as an application for initial clinical privileges.

SECTION 2. TEMPORARY CLINICAL PRIVILEGES

Upon the recommendation of a Chief of Service, and the concurrence of the President, the CEO may, at her/his sole discretion, grant temporary privileges to a physician, podiatrist, dentist or advance practice professional for a specified period of time not to exceed 120 days. For the purposes of any rights and responsibilities set forth in the Medical Staff Bylaws, the recipient of the grant of temporary privileges is not a member of the Medical Staff.

SECTION 3. DISASTER PRIVILEGES

Disaster privileges are granted only when the emergency management plan has been activated, and the organization is unable to meet immediate patient needs. The CEO may designate one of the following individuals to grant disaster privileges subsequent to review of the physician's file and determine that the physician meets the present, important patient care needs:

A. Medical Care Director
B. Medical Staff Director
C. Operation Chief

The above individual's job duties are defined in the Hospital Incident Command System (HICS) manual.

SECTION 4. TELEMEDICINE PRIVILEGES

Healthcare professionals who provide healthcare services to the Hospital's patients through a telemedicine link or modality must do so under a grant of privileges from the Hospital if these services include patient care and treatment, as evidenced by making clinical evaluations or medical decisions that impact the care and/or treatment of the patient; A grant of privileges is not necessary to merely provide a second opinion, so long as no entries are to be made in the patient's medical record at the Hospital.

An applicant for telemedicine privileges shall be credentialed and considered for a grant of privileges by the Hospital through one of the following credentialing pathways:

A. Standard Pa.7 (n)12.9 (e l)8.2 (i)-2.6 (p (:0.663 0 6 (nt)-ho (c)-2.7 ( )10.9 d1.6 -399 (i/MCID 24 BDC

pending completion of the investigation of the circumstances giving rise to the Summary Suspension according to the procedures described in Section 4 herein.

K. It shall be the duty of the President and any Chief of Service to cooperate with the CEO in enforcing all Summary Suspensions. Summary Suspension shall continue until lifted or modified by the CEO or the Board.

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L. If the Summary Suspension is not terminated for any reason d

B. It shall be the duty of the President and any Chief of Service to cooperate with the CEO in enforcing all suspensions.

SECTION 4. INVESTIGATIVE PROCEDURE

If, after receiving the request for investigation and determines merit, or as otherwise provided for in the Bylaws, the President determines:

A. The request for investigation contains sufficient information to support a recommendation for corrective action, the President shall make a recommendation for action to the MEC, with or without a personal interview with the Practitioner; or

B. The request for investigation does not contain sufficient information to support a recommendation, the President shall immediately appoint a subcommittee of the MEC to do so, or, appoint an *ad hoc* investigating committee ("Investigating Committee") to obtain the necessary information.

1. The Investigating Committee shall consist of up to three (3) physicians, dentists, or podiatrists any of whom may or may not hold an appointment to the Medical Staff. This committee shall not include partners, or relatives of the subject of the investigation, nor any individual in direct economic competition with the subject of the investigation.

2. The Investigating Committee, whether it be a subcommittee of the MEC or an *ad hoc* committee, shall have available to it the full resources of the Medical Staff and the Hospital to aid in its work, as well as the authority to use outside consultants as required.

3. The Investigating Committee may require a physical and/or mental examination of the Practitioner by a physician(s) satisfactory to the Investigating Committee and that the results of such examination be made available for the Investigating Committee's consideration.

4. The subject of the investigation shall have an opportunity to meet with the Investigating Committee before it makes its report. At this meeting (but not, as a matter of right, in advance of it) the Practitioner shall be informed of the general nature of the evidence supporting the investigation and shall be invited to discuss, explain or refute it. The proceedings of an Investigating Committee are considered an administrative matter and not an adversarial proceeding. Practitioner's meeting with the Investigating Committee is not a hearing, and none of the procedural rules provided in Article XIII with respect to hearings, including the right to have legal counsel present, apply. A summary of the

F. In circumstances where the affected Practitioner is serving a Summary Suspension imposed prior to or during an investigation, the MEC recommendation shall, in addition to other recommendations, make a recommendation to the CEO and the Board as to whether or not the Summary Suspension should be lifted, modified or continued.

SECTION 6. AUTOMATIC SUSPENSION OF PRIVILEGES OR TERMINATION OF MEMBERSHIP

Suspension of all clinical privileges, or termination of membership as well as all clinical privileges, shall occur automatically as indicated upon the occurrence of any of the following events:

A. For any Practitioner who practices at the Hospital pursuant to an exclusive agreement between the Hospital and the group/entity that employs the Practitioner: the termination of the agreement, or the termination of the Practitioner's employment/association with such group or other entity, shall result in automatic termination of the Practitioner's Medical Staff membership (except in the event the Practitioner also practices at the Hospital pursuant to another arrangement or agreement with the Hospital and/or through the University of Florida College of Medicine-Jacksonville).

B. Revocation of license to practice shall result in automatic termination of membership. Suspension of license to practice shall result in automatic suspension of all clinical privileges for a concomitant period of time and prompt initiation of an investigation in accordance with this Corrective Actions Article.

C. Failure to take appropriate steps to cause license renewal, thereby rendering the license inactive, shall result in automatic suspension of all clinical privileges. The suspension shall remain in effect

No Practitioner or applicant shall be entitled to more than one hearing with respect to the subject matter of any proposed adverse recommendation or action giving rise to a hearing right. A hearing right provided as to an initial or proposed adverse recommendation or action, whether or not exercised by the affected Practitioner or applicant, shall satisfy the requirement for a hearing right as to the final recommendation or action, which is based on the same subject matter.

SECTION 2. ACTIONS NOT GIVING RISE TO HEARING RIGHT

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HEARING

A. When a recommendation is made or action is taken that entitles a Practitioner or applicant to a hearing, the affected Practitioner or applicant shall promptly be given written Notice by the CEO or his/her designee. This Notice shall contain:

1. A statement of the recommendation/action made/taken and the general reasons for it;

2. A statement that the Practitioner or applicant has thirty (30) days from receipt of Notice within which to send to the CEO a written request for a hearing on the recommendation;

3. A statement that failure to request a hearing in the time and manner specified will result in a waiver of the Practitioner or applicant's right to a hearing and acceptance of the adverse recommendation;

4. A summary of the Practitioner or appl3.9 (a)-1.7 (c)9na h or or 62 (ppl)6.d0.8 (u1p.aa3)-4 ( )0h6ao10.(r
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receipt of the Notice with a list of witnesses the Practitioner or applicant expects to testify or present evidence on behalf of the Practitioner or applicant; and

4. Inform the Practitioner or applicant of the right to be represented at the hearing by an attorney or other person and the Practitioner or applicant's obligation to advise the CEO within fifteen (15) days of the Notice of the name and address of such attorney or other person.

B. The statement of reasons and list of supporting documents may be amended or supplemented at any time, even during the hearing, provided that the new material is relevant to the appointment or clinical privileges of the affected Practitioner or applicant, and that the Practitioner or applicant and counsel have adequate notice of the amended or supplemented materials.

SECTION 5. EXCHANGE OF WITNESS LISTS

A written list of the names and contact information of the persons expected to give testimony or present evidence in support of the recommendation giving rise to the hearing shall be provided to the affected Practitioner or applicant with the Notice of hearing. Within fifteen (15) days of the Notice of the hearing, the affected Practitioner or applicant shall provide a written list of names, addresses and phone numbers of the persons expected to give testimony or present evidence at the hearing on the Practitioner or applicant's behalf. The witness list of either party may be supplemented or amended at any time prior to the hearing, so long as there is adequate notice to the other party.

PART B: HEARING PROCEDURE

The purpose of the hearing shall be to recommend a course of action to the Board, and the duties of the Hearing Panel shall be so defined and so carried out. The hearing shall be conducted in as informal a manner as possible, subject to the rules and procedures set forth in this Article.

SECTION 1. APPOINTMENT OF HEARING PANEL

When a hearing is requested, the CEO, after considering the recommendations of the President (and that of the Chair of the Board, if the hearing is occasioned by a Board determination), shall appoint a Hearing

C. The Presiding Officer shall:

1. Act to ensure that all participants in the hearing have a reasonable opportunity to be heard and to present relevant oral testimony and/or documentary evidence and that decorum is maintained throughout the hearing;

2. Determine the order of proceeding throughout the hearing;

3. Have the authority and discretion to make rulings, consistent with these Bylaws, on all questions of procedure and admissibility of evidence; and

4. Have the authority to remove any person who is disruptive to the orderly and professional process of the hearing.

D.

SECTION 5. REQUESTS FOR DOCUMENTS

Prior to the hearing, each party shall provide to the other party documents in its possession that it plans to rely on as evidence at the hearing.

Providing documents to the other party shall not waive any privilege or confidentiality provided by law or policy to those documents; all documents will remain subject to such privilege and confidentiality protections.

SECTION 6. POSTPONEMENT OF HEARING

Postponement of the hearing beyond the time originally noticed may be requested by either party but permitted only by the Presiding Officer upon a showing of good cause.

SECTION 7. FAILURE TO APPEAR

The affected Practitioner or applicant sr.9 (e)9.2 (s)-2.3 (i)9.7 (N 7)-5 f(cy)126Tw 0 -1.15iD.8 (n)1(y)10. (c)11.2 (an)2

Officer shall admit any evidence that is commonly relied upon by reasonably prudent persons in the conduct of serious affairs.

C. The Hearing Panel may interrogate the witnesses, call additional witnesses, or request documentary evidence.

D. The Hearing Panel shall have the discretion to take official notice of any relevant matters as to which the Panel believes there can be no reasonable dispute. Official notice may also be taken of generally recognized technical or scientific facts within the specialized knowledge of any member of the Hearing Panel. 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 officially noticed matter by evidence or by written or oral presentation of authority. Reasonable additional time shall be granted, if requested, to present written rebuttal of any evidence admitted on official notice.

E. At the close of the hearing, each party shall have the right to submit a written statement concerning any issue, procedure, or alleged fact. Such written statement may take the form of a memorandum of points and authorities. The Hearing Panel may request that either party file such a statement or memorandum.

SECTION 11. STANDARD OF PROOF

The affected Practitioner or applicant has the burden of proving that the recommendation that prompted the hearing was unreasonable or not supported by evidence. Unless the Practitioner or applicant so proves, the Hearing Panel shall recommend in favor of the Professional Review Body making the recommendation.

SECTION 12. ADJOURNMENT AND CONCLUSION

The Presiding Officer may, without special notice, adjourn and reconvene the hearing at the convenience of the participants. Upon the conclusion of the presentation of oral and written evidence, the hearing shall be closed.

SECTION 13. DELIBERATIONS AND RECOMMENDATION OF THE HEARING PANEL

A. Within twenty (20) days after conclusion of the hearing, the Hearing Panel shall:

1. Conduct its deliberations outside the presence of any other person, except the Presiding Officer, and upon the request of the Hearing Panel, appropriate Hospital support personnel (including the Hospital's attorney);

2. Render a written report containing its recommendation and a concise summary of its reasons therefore, in accordance with subsection (B) herein. In the preparation of its written report with recommendation, the Hearing Panel may obtain assistance from the Presiding Officer or Hospital support staff (including the Hospital's attorney); and

3. Deliver its report to the CEO.

B. The recommendation shall be based on material allowed into evidence at the hearing, which may include: oral testimony of witnesses; documentary evidence; all officially noticed matters; and any written statement or memorandum of points and authorities submitted by the parties in accordance

with Section 10(E) of this Part. The recommendation shall comport with the burden of proof requirement set forth in Section 11 of this Part. Agreement by a majority of all the members of the Hearing Panel shall be required for the issuance of its report.

C. Upon its receipt, the CEO shall promptly communicate the Hearing Panel's report by Notice to the Professional Review Body whose adverse recommendation prompted the hearing, to the MEC and to the affected Practitioner or applicant. The CEO shall also promptly forward the Hearing Panel's report to the Board who shall take further action once the affected Practitioner or applicant exhausts or waives any appeal rights. The CEO shall make available all supporting documentation and transcripts of the hearing to the Board for its review.

PART C: APPELLATE REVIEW

SECTION 1. REQUEST FOR APPELLATE REVIEW

Within ten (10) days of notification by the CEO or designee of an adverse recommendation from the Hearing Panel, the affected Practitioner or applicant may request appellate review. The request, which shall be in writing, and be delivered to the CEO, shall include a brief statement of the facts supporting the grounds for appeal. The CEO shall promptly forward the request to the Chair of the Board. If such appellate review is not requested in a timely fashion and in the manner required, the affected Practitioner or applicant shall be deemed to have waived the right to an appeal and to have accepted the adverse recommendation of the Hearing Panel.

SECTION 2. GROUNDS FOR APPEAL

The grounds for an appeal are that:

A. There was substantial failure on the part of the Hearing Panel to comply with the hearing process set forth in Part B herein, and such failure significantly prejudiced the affected Practitioner or applicant; or

B. The recommendations of the Hearing Panel were arbitrary or capricious; or

C. The recommendations of the Hearing Panel were not supported by evidence in the record of the hearing.

SECTION 3. SCHEDULING AND NOTICE OF APPELLATE REVIEW

Within ten (10) days of receipt of a request for an appeal, the CEO shall schedule and arrange for an appellate review. The date of appellate review shall be not less than twenty (20) days nor more than forty-five (45) days from the date of receipt of the request; provided, however, that when a request for appellate review is from a Practitioner or applicant who is under a suspension then in effect, the appellate review shall be held as soon as the arrangements may reasonably be made and not more than fourteen (14) days from the date of receipt of the request. The CEO or designee shall communicate the time, date, and place where the appellate review shall occur by Notice to the affected Practitioner or applicant.

SECTION 4. APPOINTMENT OF APPELLATE REVIEW PANEL

A. The Chair of the Board shall appoint an Appellate Review Panel ("Appeal Panel") to consider the record upon which the Hearing Panel recommendation was made. The Appeal Panel shall be

composed of not less than three (3) and no more than five (5) persons, who may be members of the Board or others, including but not limited to reputable persons outside the Hospital and at least two (2) of whom hold Active Medical Staff membership.

B. Appointees to the Appeal Panel shall not have actively participated in the consideration of the matter involved at any previous level. Nor shall it include any individual who is in direct economic compeep 4.6 (c)9.3 (t)(o)10.d(c)T.2 (t)-4.6 ( )10 5 (8(h)2 (a7.3 (s)-2.328 (e)-t-4.5(hol)-53 (e16 (i)9 (de)-(e16 (i -1

with instructions for remedial action. Agreement by a majority of all the members of the Appeal Panel shall be required for the issuance by the Appeal Panel of any recommendation or report. In the preparation of its written report with recommendation, the Appeal Panel may obtain assistance from the Hospital support staff (including the Hospital attorney).

B. dv-4.6on, t(t)-4.6

MEC appointed by the President. The Hospital CEO or designee shall be an ex-officio non-voting member of any CRC.

C. The members of the CRC

E. The MEC may, without vote by the Medical Staff, recommend such amendments to the Bylaws as are, in the MEC's judgment, technical or legal modifications or clarifications, reorganization or renumbering or due to punctuation, spelling or other errors of grammar or expression. Such