KETTERING HEALTH
MEDICAL STAFF BYLAWS

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DEFINITIONS

Advanced Practice Provider or **APP** means those physician assistants, advanced practice registered nurses, and other eligible APPs, as designated in the APP Policy, who have applied for, or who have applied for and been granted, Privileges to practice at the Hospital either independently (as applicable), or in collaboration with or under the supervision of a Medical Staff appointed Physician, Dentist, or Podiatrist with Privileges at the Hospital.

Adverse means a recommendation or action of the Medical Executive Committee or Board that denies, limits (*e.g.,* suspension, restriction, *etc.*) for a period in excess of fourteen (14) days, or terminates a Practitioner's Medical Staff appointment and/or Privileges on the basis of clinical competency or professional conduct.

Affiliate Hospital means the Kettering Health wholly-owned hospitals, other than the Hospital at issue.

Board means the Hospital's governing body which holds ultimate responsibility for the Hospital and its Medical Staff. A reference to the Board shall include a Board committee or individual authorized by the Board to act on its behalf in designated matters.

Centralized Credentialing Office or **CCO** means the Kettering Health Centralized Credentialing Office that conducts credentialing verification functions for the Hospital as set forth in the Medical Staff governing documents.

Chief Medical Officer or CMO means the Physician assigned by the Hospital to work with the Medical Staff on matters of medical administration, quality oversight, and other duties as assigned.

Chief of Staff means the qualified Practitioner selected in the manner set forth in these Bylaws to be the leader of, and spokesperson for, the Medical Staff. The Chief of Staff shall chair of the Medical Executive Committee.

Clinical Privileges or **Privileges** means the authorization granted by the Board to a Practitioner or APP to provide patient care, treatment, and/or clinical services at/for the Hospital, pursuant to an applicable Delineation of Privileges, based upon the individual's professional license, education, training, experience, competence, ability, and judgment.

Conflict of Interest means any personal, professional, financial, or business circumstance or relationship that either is in direct conflict with a Practitioner's official duties, loyalties, activities and/or responsibilities on behalf of the Medical Staff, or that may be perceived as such, so that the competing interest may inappropriately influence a Practitioner to act in his/her own behalf rather than in the best interest of the Medical Staff and/or the Hospital.

Dentist means an individual who holds a Doctor of Dental Medicine (D.M.D.) or Doctor of Dental Surgery (D.D.S.) degree and is currently licensed to practice dentistry in Ohio.

Emergency Call means a process whereby patients may be provided medical/clinical care, treatment, and/or services specific to the patient's condition by a Practitioner, with appropriate

Privileges, scheduled to be available to respond and/or present to the Hospital upon request of other Practitioners, APPs, or Hospital staff.

Exclusive Contract means a contract between the Hospital and a Practitioner(s) or group practice providing for the exclusive delivery of certain professional healthcare services by the Practitioner(s) or by Practitioners employed by or contracted with the group practice.

Ex Officio means appointment to serve as a member of a body by virtue of an office or position held. *Ex Officio* members shall not be counted for purposes of determining a quorum nor shall they have voting rights unless otherwise expressly stated.

Federal Health Program means Medicare, Medicaid, TriCare, CHIP, or any other federal or state program providing health care benefits that is funded directly or indirectly by the United States government.

Focused Professional Practice Evaluation (FPPE) means the process of evaluating the Privilege-specific competence of a Practitioner or APP as it relates to the performance of Privileges newly granted to a Practitioner/APP or as a result of quality-of-care concerns.

Good Standing means a Practitioner who, during the current term of appointment with or without a grant of Privileges, has an absence of corrective action and has maintained qualifications for Medical Staff appointment (*i.e.,* assigned category) and Privileges (as applicable). If a Practitioner has been automatically suspended for delinquent medical records during an appointment/Privilege period and has subsequently taken appropriate action, such automatic suspension for delinquent medical records shall not adversely affect the Practitioner's Good Standing status.

Hospital means, as the context requires, Kettering Health (KH):

- KH Dayton
- KH Greene Memorial
- KH Hamilton
- Indu & Raj Soin Medical Center (Soin)
- KH Main Campus
- KH Miamisburg
- KH Troy
- KH Washington Township

including each such Hospital's provider-based locations.

Hospital President means the individual appointed by the Board to act on its behalf in the overall management of the Hospital.

Joint Conference Committee or JCC means the Board advisory committee that serves, on an *ad hoc* basis, as an official liaison between the Medical Staff and the Board with the composition and duties as described in the JCC charter.

Medical Executive Committee or **MEC** means the executive committee of the Medical Staff.

Medical Staff means the formal organization of Practitioners who have been granted Medical Staff appointment at the Hospital with such responsibilities and Prerogatives as defined in the Medical Staff category to which each has been appointed. For purposes of these Medical Staff Bylaws:

- KH Dayton and KH Washington Township (which is a campus of KH Dayton) have a single Medical Staff (hereinafter collectively referred to as KH Dayton/Washington Township).
- KH Greene Memorial and Indu & Raj Soin Medical Center have elected to have a unified Medical Staff (hereinafter collectively referred to as KH Greene/Soin or the KH Greene/Soin unified Medical Staff).
- KH Hamilton has a single Medical Staff.
- KH Main Campus, KH Miamisburg, and KH Troy have elected to have a unified Medical Staff (hereinafter collectively referred to as KH Main/Miamisburg/Troy or the KH Main/Miamisburg/Troy unified Medical Staff).

A reference to Medical Staff appointment shall mean the same thing as Medical Staff membership for purposes of the Medical Staff governing documents.

Medical Staff Appointee (Appointee) or **Medical Staff Member (Member)** means a Practitioner who has been granted appointment to the Medical Staff as defined by the assigned Medical Staff category (*i.e.,* a member of the Medical Staff).

Medical Staff Bylaws or **Bylaws** means the articles and amendments herein that constitute the base governing document of the Medical Staff.

Medical Staff Department or Department means a clinical division of the Medical Staff established in accordance with the procedure described in these Bylaws and set forth in the Medical Staff Organization Manual. Departments may be further divided into clinical "**Sections**" each led by a "**Section Chair**."

Medical Staff Department Chair or Department Chair means a qualified Practitioner selected in the manner set forth in these Bylaws to lead a Medical Staff Department.

Medical Staff Manual or **Manual** and **Medical Staff Policy** means those additional Medical Staff governing documents recommended by the Medical Executive Committee and approved by the Board which serve to implement and supplement the Medical Staff Bylaws including, but not limited to: the Medical Staff Credentials Manual ("Credentials Manual"); the Medical Staff Organization and Functions Manual ("Organization Manual"); the Advanced Practice Provider Manual ("APP Manual"); the Practitioner/APP Professionalism Policy, the Practitioner/APP Impairment Policy, the Practitioner/APP Peer Review Policy; and the Practitioner/APP Professional Practice Evaluation (FPPE/OPPE) Policy.

Medical Staff Services means the Hospital administrative department that provides support services to the Medical Staff.

Oral Maxillofacial Surgeon or **Oral Surgeon** or **Maxillofacial Surgeon** means a Dentist who has successfully completed an accredited post-graduate/residency program in oral/maxillofacial surgery.

Ongoing Professional Practice Evaluation (OPPE) means a documented compilation of ongoing data collected for the purpose of assessing a Practitioner's/APP's quality of care and clinical competence. The information gathered during this process is considered as part of a decision to maintain, modify, suspend, or terminate existing Privilege(s) prior to, or at the end of, a designated appointment/Privilege period. This process not only allows potential problems with a Practitioner's/APP's performance to be identified and resolved as soon as possible but also fosters a more efficient, evidence-based Privilege regrant process.

Patient Encounter means a professional contact between a Practitioner and a patient (including an admission, consultation, or diagnostic, operative, or invasive procedure) at the Hospital or a provider-based location thereof.

Physician means an individual who holds a Doctor of Medicine ("M.D."), Doctor of Osteopathic Medicine ("D.O."), or Bachelor of Medicine/Bachelor of Surgery ("MBBS") degree and is currently licensed to practice medicine in Ohio.

Podiatrist means an individual who holds a Doctor of Podiatric Medicine (D.P.M.) degree and is currently licensed to practice podiatry in Ohio.

Practitioner means, unless otherwise provided, a Physician, Dentist, Podiatrist or Psychologist.

Prerogative means the right to participate, by virtue of Medical Staff category, granted to a Medical Staff Member and subject to the ultimate authority of the Board and the conditions and limitations imposed in the Medical Staff governing documents.

Professional Liability Insurance means professional liability insurance coverage of such kind, in such amount, and with such insurers as acceptable to the Board.

Psychologist means an individual who holds a doctoral degree in psychology or school psychology, or a doctoral degree deemed equivalent by the Ohio Board of Psychology, and is currently licensed to practice psychology in Ohio.

Rules & Regulations means the rules and regulations of the Medical Staff, as recommended by the Medical Executive Committee and approved by the Board, that set standards of clinical practice and address issues related to clinical care, treatment, and services provided by Practitioners and APPs with Privileges at the Hospital.

Special Notice means written notice sent by (a) certified mail, return receipt requested; or (b) by personal delivery service with signed acknowledgment of receipt.

System means Kettering Health.

Use of an Authorized Designee: Whenever an individual is authorized in the Medical Staff governing documents to perform a duty by virtue of his/her position (*e.g.,* the Hospital President,

Hospital CMO, Chief of Staff, Department Chair, *etc.*), then reference to the individual shall also include the individual's authorized designee.

ARTICLE 1
PREAMBLE

WHEREAS, Kettering Health is a healthcare system that includes the Hospitals; and,

WHEREAS, self-governing Medical Staffs serve the Hospitals within the System with the purpose of providing patient care, education, and research; and,

WHEREAS, the Medical Staff of each Hospital has separately and voluntarily adopted and approved this single, aligned Medical Staff Bylaws document in order to organize itself and establish methods of self-governance to carry out the herein delegated duties with unique features and/or differences at a Hospital indicated herein;

NOW, THEREFORE, the Medical Staff and Hospital administration shall work cooperatively to accomplish the Medical Staff's duties and responsibilities at the Hospital in an orderly fashion. The Medical Staff shall function and act in accordance with the Medical Staff Bylaws, Manuals/Policies, and Rules & Regulations.

ARTICLE 2
PURPOSE

2.1. The Medical Staff Bylaws, Manuals/Policies, and Rules & Regulations are subject to the authority of the Board in those matters where the Board has ultimate legal responsibility.

2.2. The Medical Staff Bylaws, Manuals/Policies, and Rules & Regulations are not intended to be and are not to be construed as a contract. A Practitioner is not an employee or an independent contractor of the Hospital unless such relationship is established in writing between the Practitioner and the Hospital. Any/all contracts of association or employment shall control contractual and financial relationships between the Hospital and Practitioners.

2.3. The Board delegates to the Medical Staff (through the Medical Staff officers, the Medical Staff Departments/Sections and their Department Chairs/Section Chairs, the Medical Staff committees and their members/authorized agents) the authority and duty/responsibility to monitor the quality of medical care in the Hospital and report thereon to the Board in addition to the authority and duty/responsibility to make recommendations to the Board concerning Medical Staff appointment/reappointment and privileging matters. The Medical Staff desires to organize itself and establish methods of self-governance to carry out these delegated duties.

2.4. The purposes of the Medical Staff are to:

2.4.1 Provide a mechanism for accountability to the Board for the appropriateness of patient care services and for the professional and ethical conduct of each Practitioner appointed to the Medical Staff and each Practitioner/APP granted Privileges at the Hospital so that patient care provided at the Hospital is maintained at a level of quality and efficiency that is commensurate with generally recognized standards of care.

2.4.2 Serve as the collegial body through which Practitioners/APPs may, as applicable, obtain Medical Staff appointment and/or Privileges at the Hospital, fulfill their obligations at the Hospital, and practice in an environment that promotes quality and efficient patient care.

2.4.3 Provide, on behalf of the Hospital, an appropriate educational setting and maintain high scientific and educational standards for continuing medical/other professional education programs for Practitioners and APPs.

2.4.4 Provide an orderly and systematic means by which Practitioners can give input to the Board and Hospital President on medico-administrative problems and on the Hospital's policy-making and planning processes.

2.4.5 Initiate, maintain, and enforce the Medical Staff Bylaws, Manuals/Policies, and Rules & Regulations for self-governance of the Medical Staff.

2.4.6 Account to the Board for the quality of medical/other professional care provided by Practitioners and APPs to patients which may include the following:

(a) Acting on reports from Medical Staff Departments/Sections and Medical Staff committees.

(b) Providing reports and recommendations to the Board regarding Medical Staff appointments, reappointments, granting/regranting of Privileges, and Delineations of Privileges.

(c) Providing reports and recommendations to the Board regarding Practitioner/APP corrective actions.

(d) Reviewing and evaluating on a continuing basis the clinical competency of Practitioners and APPs who have been granted Privileges at the Hospital via professional practice evaluation (*i.e.,* FPPE/OPPE, peer review) of their clinical work.

(e) Collaborating with Hospital administration and the Board regarding institutional planning, budgeting, and the appropriate utilization of available resources.

2.4.7 Discharge those duties and responsibilities delegated to it by the Hospital Board to support a high level of professional performance by all Practitioners and APPs granted Privileges to practice in the Hospital.

ARTICLE 3
MEDICAL STAFF APPOINTMENT & PRIVILEGING

3.1. NATURE OF MEDICAL STAFF APPOINTMENT & PRIVILEGES

3.1.1 The Board has final authority for appointments and reappointments to the Medical Staff and for granting/regranting Privileges based upon the recommendations of the Medical Staff.

3.1.2 Applications for Medical Staff appointment and/or Privileges are processed in accordance with the applicable procedure set forth in the Medical Staff Credentials Manual based upon the professional criteria set forth in this Article.

3.1.3 Appointment to the Medical Staff and/or granting of Privileges at the Hospital shall be extended only to professionally competent Practitioners who continuously meet the qualifications, standards, and requirements set forth in these Bylaws and the Medical Staff Manuals/Policies.

3.1.4 Appointment to the Medical Staff is separate and distinct from a grant of Privileges. A Practitioner can be a Medical Staff Appointee with or without Privileges or be granted Privileges without a Medical Staff appointment.

3.1.5 A Practitioner who is granted Medical Staff appointment is entitled to such Prerogatives and is responsible for fulfilling such obligations as set forth in these Bylaws and the Medical Staff category to which the Practitioner is appointed. Medical Staff appointment shall confer only such Privileges as are granted in accordance with these Bylaws and the Medical Staff Manuals/Policies.

3.1.6 No Practitioner, including those in a medico-administrative position by virtue of a contract with the Hospital, shall treat or otherwise provide care, treatment, and/or services to a patient in the Hospital unless the Practitioner has been granted Privileges to do so.

3.1.7 A Practitioner who is granted Privileges at the Hospital is entitled to exercise such Privileges and is responsible for fulfilling such obligations as set forth in these Bylaws and the applicable Privilege set.

3.2. QUALIFICATIONS FOR MEDICAL STAFF APPOINTMENT AND/OR PRIVILEGES

3.2.1 In General

(a) Only Practitioners who can, as applicable, satisfactorily document their education/training, licensure, experience, judgment, individual character, demonstrated current clinical competence, and other qualifications as detailed in this Section 3.2 shall be eligible for Medical Staff appointment and/or Privileges at the Hospital.

3.2.2 Eligibility/Baseline Qualifications. Unless otherwise provided in the Medical Staff governing documents, to be eligible for appointment to the Medical Staff and/or Privileges, a Practitioner must:

(a) Have and maintain a current license to practice his/her profession in the State of Ohio. Practitioners shall meet the continuing education requirements necessary to maintain such professional license as determined by the applicable state licensing entity.

(b) Have and maintain, if necessary for the Privileges requested, a current valid Drug Enforcement Administration (DEA) registration.

(c) Document successful completion of professional education and residency/other training requirements as applicable to the Privileges requested.

(d) Possess current, valid Professional Liability Insurance coverage.

(e) Be able to participate in Federal Health Programs.

(f) Satisfy the board certification requirements, as applicable, set forth in Section 3.2.4 of these Bylaws.

(g) Be able to read and understand the English language, to write and communicate verbally in the English language in an intelligible manner, and to prepare medical record entries and other required documentation in a legible and professional manner.

(h) Comply with state and/or federal vaccination requirements, if any, and implementing System/Hospital policies or obtain an approved exemption therefrom.

3.2.3 Additional Qualifications

(a) Provide evidence of the Practitioner's ability to work with others in a positive, professional, cooperative, and collegial manner.

(b) Document and demonstrate a current ability to competently perform the Privileges requested with or without a reasonable accommodation.

(c) Document prior and current experience demonstrating a continuing ability to provide patient care, treatment, and/or services at an acceptable level of quality and efficiency and consistent with available resources and applicable standards of care.

(d) Document and demonstrate adherence to the applicable code of professional ethics and good character/judgment.

(e) Agree to fulfill the applicable Medical Staff duties.

(f) Obtain and maintain a provider number for Medicare issued by the Centers for Medicare and Medicaid Services and a provider number for Medicaid issued by the Ohio Department of Medicaid and be a Medicare and Medicaid participating provider.

(g) Comply with applicable Conflict of Interest policies, if any.

(h) Comply with Medical Staff requirements regarding criminal background checks.

(i) Satisfy such other qualifications as are set forth in the applicable Medical Staff category, Delineation of Privileges (if any), and as may be otherwise recommended by the Medical Executive Committee and approved by the Board.

3.2.4 Board Certification

(a) Unless otherwise provided herein, all Physicians, Podiatrists, and Oral Surgeons shall be board certified (or board eligible) in the specialty/subspecialty in which the Practitioner seeks Privileges at the time of initial application for Medical Staff appointment and/or Privileges as follows:

(1) Physicians: By an American Board of Medical Specialties board or by an American Osteopathic Association board applicable to the Physician's specialty/sub-specialty.

(i) A Physician who is board certified in a subspecialty is not required to also maintain certification with the primary board unless otherwise required by the applicable certifying board or Delineation of Privileges (*e.g.,* a Physician who is board certified in gastroenterology is not also required to maintain internal medicine board certification).

(2) Podiatrists: By the American Board of Podiatric Medicine or the American Board of Foot and Ankle Surgery.

(3) Oral Surgeons: By the American Board of Oral & Maxillofacial Surgery.

(b) A Physician, Podiatrist, or Oral Surgeon who is a qualified candidate for board certification at the time of initial application for Privileges shall have the time period as set by the applicable certifying board following the date of completion of residency or fellowship training to become board certified. If the applicable certifying board does not specify a time period for board certification, the Physician, Podiatrist, or Oral Surgeon shall have five (5)

years following the date of completion of residency or fellowship training to become certified.

(c) Physicians, Podiatrists, and Oral Surgeons granted Privileges at the Hospital prior to February 5, 2025:

(1) Who have board certification on February 5, 2025 must maintain board certification unless a waiver is otherwise granted.

(2) Who had initial board certification but allowed that certification to lapse before February 5, 2025 are not required to regain and maintain board certification.

(3) Who are in the process of obtaining initial board certification on February 5, 2025 are required to attain board certification within the time period specified in subsection (b) and, thereafter, maintain board certification unless a waiver is otherwise granted.

(d) Physicians, Podiatrists, and Oral Surgeons granted Privileges at the Hospital on or after February 5, 2025:

(1) Must have, or obtain within the time period specified in subsection (b), initial board certification and maintain board certification unless a waiver is otherwise granted.

(e) Practitioners granted Medical Staff appointment to the associate, retired, or honorary Medical Staff category, without Privileges, are not required to be board certified.

3.2.5 Waiver Process

(a) A written request for a waiver of the board certification qualification may be submitted by the Practitioner for consideration by the Credentials Committee, the Medical Executive Committee, and the Board.

(b) Board certification may be waived, at the sole discretion of the Board, based upon the Practitioner's demonstrated exceptional circumstances and a Board determination that such waiver will serve the best interests of patient care.

(c) The Credentials Committee will review the waiver request and provide its written recommendation to the Medical Executive Committee. Following consideration of the recommendation from the Credentials Committee, the Medical Executive Committee will make a written recommendation to the Board regarding whether to grant or deny the request for a waiver. Upon receipt of the Medical Executive Committee's recommendation, the Board shall either grant or deny the waiver request in its sole discretion.

(d) Once a waiver is granted, it shall remain in effect from the time it is granted until the Practitioner's resignation or termination of Medical Staff appointment and/or Privileges, unless a shorter time period is otherwise recommended by the Medical Executive Committee and approved by the Board. The Practitioner must thereafter reapply for the waiver.

(e) No Practitioner is entitled to a waiver. A determination by the Board not to grant a Practitioner's request for a waiver; or, the Hospital's inability to process an application; or, termination of a Practitioner's Medical Staff appointment and/or Privileges based upon failure to satisfy the qualifications for Medical Staff appointment and/or Privileges does not give rise to any procedural due process rights pursuant to these Bylaws nor does it create a reportable event for purposes of federal or state law.

(f) Unless an exception applies or a waiver is requested and subsequently granted, a Practitioner's failure to:

(1) Satisfy the board certification (or eligibility) requirement at the time of initial application shall result in the Hospital's inability to process the application as a result of the Practitioner's failure to meet baseline qualifications.

(2) Continuously satisfy the board certification requirement following attainment of Medical Staff appointment and/or Privileges shall result in termination of Medical Staff appointment and Privileges for failure to meet baseline qualifications.

(g) The waiver process may be used, at the sole discretion of the Board, in the event that the Credentials Committee and the Medical Executive Committee recommend waiver of a qualification(s), other than or in addition to board certification, set forth in these Bylaws.

3.2.6 No Entitlement

No Practitioner shall be entitled to Medical Staff appointment and/or Privileges at the Hospital merely by virtue of the fact that he/she: holds a certain degree; is duly licensed to practice his/her profession in this or any other state; is board certified; is a member of any professional organization; had in the past, or presently has, appointment and/or privileges at another hospital or healthcare entity; or is employed by or contracts with the Hospital.

3.2.7 Nondiscrimination

No Practitioner shall be denied appointment and/or Privileges on the basis of: race; color; sex (including pregnancy); sexual orientation; gender identity; gender expression; transgender status; age (40 and older); religion; marital, familial, or health status; national origin; ancestry; disability (provided that the applicant can competently exercise the Privileges requested with or without a reasonable

accommodation); genetic information; veteran or military status; or any other characteristic(s) or class protected by applicable law.

3.3. RESPONSIBILITIES OF MEDICAL STAFF APPOINTMENT & EXERCISE OF PRIVILEGES

3.3.1 Unless otherwise provided in the Medical Staff governing documents, each Practitioner granted Medical Staff appointment and/or Privileges at the Hospital shall, as applicable to the Medical Staff appointment and/or Privileges granted to each such Practitioner:

(a) Direct the care of his/her patients within the scope of the Practitioner's Privileges subject to the Medical Staff governing documents.

(b) Provide, or arrange for, continuous care and supervision of each patient in the Hospital for whom services are being provided within the Practitioner's area of professional competence.

(c) Participate appropriately in Medical Staff peer review activities as assigned including, but not limited to, as a member or agent of a peer review committee (*e.g.,* as a peer reviewer, proctor, *etc.*).

(d) Abide by the Medical Staff Bylaws and Manuals/Policies, System and Hospital policies (including, but not limited to, the Corporate Responsibility Plan/Program and policies related to HIPAA privacy/confidentiality, Conflicts of Interest, *etc.*), and applicable laws, rules, regulations, and accreditation standards.

(e) As a precondition to the exercise of Privileges, a Practitioner must arrange for appropriate coverage (*i.e.,* designate another Practitioner with comparable Privileges who has agreed to provide backup coverage) for the Practitioner's patients in the event the Practitioner is not available. It is the Practitioner's and/or the designated alternate Practitioner's responsibility to notify Medical Staff Services of any changes to the designated alternate Practitioner.

(f) Participate in such Medical Staff, Department/Section, Medical Staff committee, and System/Hospital functions and educational activities for which he/she is responsible as required by the Medical Staff governing documents.

(g) Prepare and complete medical/electronic health records and other required documentation within the time period(s) required by the Hospital.

(h) Appropriately utilize the Hospital's electronic health record system for order entry and for all other appropriate functionalities.

(i) Call for consultations and respond to requests for consultations as required by patient condition and applicable System/Hospital policies and/or the Medical Staff Rules & Regulations.

(j) Timely complete required Hospital education and training as directed by the Medical Executive Committee.

(k) Comply with such notice requirements as are set forth in the Medical Staff governing documents.

(l) Abide by the code of ethics prescribed by the Practitioner's profession (*e.g.,* AMA, AOA, *etc.*).

(m) Work in a cooperative and professional manner with others so as not to adversely affect the delivery of quality patient care.

(n) Participate in quality assurance/performance improvement, peer review, and utilization review activities whether related to oneself or others.

(o) Participate in professional practice evaluation (*i.e.,* FPPE and OPPE) activities.

(p) Cooperate with review of a Practitioner's (including his/her own) conduct, clinical competence, or other qualifications for Medical Staff appointment and/or Privileges and refrain from directly or indirectly interfering, obstructing, or hindering any such review (*e.g.,* with threats, by withholding information, or by refusing to perform or participate in assigned responsibilities related thereto).

(q) Comply with Hospital health screening and immunization requirements (or be granted an exemption thereto) as set forth in applicable System/Hospital policies and/or the Medical Staff governing documents.

(r) Abide by the terms of the Notice of Privacy Practices prepared and provided to patients as required by the federal Health Insurance Portability and Accountability Act of 1996, as may be amended from time to time. Such notice is available in Medical Staff Services or on the Hospital intranet.

(s) Neither receive from or pay to another Practitioner, either directly or indirectly, any part of a fee received for professional services that is in violation of applicable state and federal laws and regulations.

(t) Satisfy such additional responsibilities as may be set forth in the applicable Medical Staff category, in the Medical Staff governing documents, and/or as may be otherwise recommended by the Medical Executive Committee and approved by the Board.

3.3.2 Failure to satisfy any of the aforementioned responsibilities may be grounds for denial of Medical Staff reappointment and/or regrant of Privileges or corrective action pursuant to the Medical Staff governing documents.

3.4. QUALIFICATIONS/RESPONSIBILITIES FOR APPOINTMENT WITHOUT PRIVILEGES

3.4.1 Practitioners appointed to a Medical Staff category without Privileges shall meet such qualifications and fulfill such obligations as set forth in the applicable Medical Staff category and/or as otherwise recommended by the MEC and approved by the Board.

3.5. DURATION OF MEDICAL STAFF APPOINTMENT/REAPPOINTMENT & GRANT/REGRANT OF PRIVILGES

3.5.1 Medical Staff appointment/reappointment and granting/regranting of Privileges will be for no more than three (3) years.

3.5.2 Appointments/reappointments and/or grants of Privileges for a period of less than three (3) years shall not be deemed Adverse.

3.6. OVERVIEW OF THE CREDENTIALING, APPOINTMENT/REAPPOINTMENT & PRIVILEGING PROCESS

3.6.1 The System has established a Centralized Credentialing Office (CCO) to collect and verify credentials information with respect to applications for Medical Staff appointment, reappointment, and/or Privileges at the Hospital.

3.6.2 Unless otherwise provided in the Medical Staff Bylaws or Manuals/Policies:

(a) Applications for appointment, reappointment and/or Privileges are submitted to the CCO which reviews the applications for completeness, collects required information, performs primary source verifications, and submits complete applications with accompanying documentation to Medical Staff Services which shall perform further verifications before releasing the complete application for review by the applicable Department Chair/Section Chair, Credentials Committee, and Medical Executive Committee.

(b) Initial appointment and reappointment to the Medical Staff and/or the granting/regranting of Privileges shall be made by the Board (or as otherwise provided in the Medical Staff Credentials Manual or APP Manual). The Board shall act on applications for Medical Staff appointment, reappointment, and/or Privileges only after there has been a recommendation from the Medical Executive Committee (or as otherwise provided in the Medical Staff Credentials Manual or APP Manual). All individuals and committees required to act on applications for Medical Staff appointment, reappointment, and/or Privileges must do so in a timely

manner in accordance with the applicable procedure set in the Medical Staff Credentials Manual (for Practitioners) or APP Manual (for APPs).

3.6.3 Temporary Privileges are granted in accordance with the procedure (and for the time period) outlined in the Medical Staff Credentials Manual (for Practitioners) or in the APP Manual (for APPs).

3.6.4 Details regarding the mechanisms for credentialing/re-credentialing, processing applications for initial appointment, for reappointment, and for granting/regranting Privileges to Practitioners are set forth in the Medical Staff Credentials Manual.

3.6.5 Details regarding the mechanisms for credentialing/recredentialing and processing applications for granting/regranting Privileges to APPs are set forth in the APP Policy.

3.7. CONTRACTUAL ARRANGEMENTS

3.7.1 A Practitioner who is or will be providing professional services pursuant to a contract with the Hospital (or for a group holding a contract with the Hospital) must obtain and maintain Medical Staff membership and/or Privileges in accordance with the procedures described in these Bylaws and the Medical Staff Credentials Manual.

3.7.2 The effect of the expiration or termination of a Practitioner's contract with the Hospital (or the expiration or termination of a Practitioner's association with a group holding a contract with the Hospital) upon a Practitioner's appointment and/or Privileges at the Hospital will be governed solely by the terms of the Practitioner's contract with the Hospital (or with the group holding the contract with the Hospital). If the contract is silent on the matter, then contract expiration or termination alone (or the expiration or termination of the Practitioner's association with the group holding the contract with the Hospital) will not affect the Practitioner's appointment and/or Privileges at the Hospital with the exception set forth in Sections 3.7.4 and 3.7.5 below.

3.7.3 The Board, after consultation with the MEC, may determine that an exclusive contractual arrangement between an individual Practitioner, group of Practitioners, or, in some instances, an entire Department/Section is the preferred manner to deliver a service or accomplish a function.

3.7.4 Unless the written contractual arrangement specifically provides otherwise, or unless otherwise required by law, if an exclusive or semi-exclusive contract under which a Practitioner is engaged is terminated or expires (or if the relationship of a Practitioner with the group that has the exclusive or semi-exclusive contractual relationship with the Hospital is terminated or expires), then the Practitioner's Medical Staff appointment and those Privileges covered by the exclusive or semi-exclusive contract will likewise automatically terminate without the right of access to the hearing and appeal procedures set forth in these Bylaws. The Board, in its sole discretion, may waive this automatic termination result.

3.7.5 If the Hospital determines to close a Department/Service or enter into an exclusive or semi-exclusive contract for a particular service(s), any Practitioner that currently holds Privileges to provide such service(s) but who does not meet the closed Department/Section criteria and/or is not a party to the exclusive or semi-exclusive contract (or otherwise employed by or contracted with the group that holds the exclusive or semi-exclusive contract with the Hospital) may not exercise such Privileges as of the effective date of the closed Department/Section or exclusive or semi-exclusive contract irrespective of any remaining time in the current appointment/Privilege period.

3.8. RESIDENTS AND FELLOWS

3.8.1 Residents and fellows participating in a training program are not Members of the Medical Staff, are not eligible to be granted Privileges (with the limited exception set forth in Section 3.8.3) and shall not be entitled to any of the rights provided under these Bylaws or the Medical Staff Manuals/Policies including, but not limited to, hearing and appeal rights.

3.8.2 Residents and fellows participating in a training program will act under the auspices of their approved and accredited program of graduate medical education (GME) in carrying out clinical care at the Hospital in accordance with written educational protocols delineating the roles, responsibilities, and scope of clinical activities for such trainees consistent with and subject to applicable laws, rules, and regulations. Additional information regarding resident and fellow trainees is set forth in the Hospital GME residency/fellowship program documents.

3.8.3 Residents and fellows who moonlight outside of their graduate medical education program shall do so in accordance with the requirements set forth in the applicable section of the Medical Staff Credentials Manual (*i.e.,* after requesting and being granted moonlighting Privileges).

ARTICLE 4
CATEGORIES OF THE MEDICAL STAFF

All appointments to the Medical Staff shall be made by the Hospital Board in accordance with these Bylaws and the Medical Staff Credentials Manual and shall be to one of the categories of the Medical Staff set forth in this Article.

4.1. ACTIVE MEDICAL STAFF CATEGORY & AND EMERITUS-ACTIVE DESIGNATION

4.1.1 Qualifications. Practitioners appointed to the active Medical Staff category must:

(a) Meet the qualifications set forth in Section 3.2.

(b) Engage in significant clinical practice at the Hospital and have at least fifty (50) Patient Encounters per year.

(1) After three (3) consecutive years in which a Member of the active Medical Staff category fails to have at least 50 (fifty) Patient Encounters per year at the Hospital, the Member shall be automatically transferred to another appropriate Medical Staff category, if any, for which the Member is qualified in the absence of a showing, satisfactory to the MEC and Board, that this was due to unusual circumstances unlikely to occur again in the next appointment/Privilege period.

(2) If the Member fails to qualify for another Medical Staff category, he/she will be considered ineligible for appointment and Privileges.

(3) An automatic transfer to another Medical Staff category or failure to be reappointed based upon this section shall not entitle a Practitioner to the procedural due process rights set forth in these Bylaws.

(c) Actively participate in Medical Staff activities and responsibilities, such as committee and Department/Section assignments.

4.1.2 Prerogatives. Practitioners appointed to the active Medical Staff category may:

(a) Exercise the Privileges granted.

(b) Attend meetings of the Medical Staff and of the Medical Staff Department/Section and Medical Staff committees of which the Practitioner is a member.

(c) Vote on Medical Staff matters and on matters of the Department/Section and Medical Staff committees of which the Practitioner is a member.

(d) Hold a Medical Staff office subject to satisfaction of the applicable qualifications.

(e) Serve as a Department Chair or Department Vice Chair (if any) or Section Chair (if any) subject to satisfaction of the applicable qualifications.

(f) Serve as a member or chair of a Medical Staff committee subject to satisfaction of the applicable qualifications.

4.1.3 Responsibilities. Practitioners appointed to the active Medical Staff category must:

(a) Satisfy the responsibilities set forth in Section 3.3.

(b) Contribute to the administrative affairs of the Medical Staff.

(c) Participate in the care of unassigned patients, Emergency Call, and other specialty coverage programs as requested by the Medical Staff, Hospital administration, or Board. Practitioners with unique or scarce expertise are expected to collegially assist other Practitioners when urgent patient care needs arise.

(d) Timely respond to consultation requests.

(e) Attend meetings of the Medical Staff, his/her Department and Section, and those committees on which he/she serves.

(f) Serve on Medical Staff committees as assigned.

(g) Faithfully perform the duties of any office or position to which elected or appointed.

(h) Participate in Hospital and Medical Staff education programs as appropriate.

(i) Discharge other Medical Staff functions as may be requested or required from time to time.

(j) Timely pay Medical Staff application fees, dues (if any), and assessments, as applicable.

4.1.4 Emeritus-Active Designation

(a) Practitioners appointed to the active Medical Staff category will attain "emeritus-active" designation on the Practitioner's 65th birthday.

(b) Practitioners appointed to the active Medical Staff category with emeritus-active designation must continue to meet the qualifications set forth in Section 4.1.1.

(c) Practitioners appointed to the active Medical Staff category with emeritus-active designation shall continue to be entitled to the Prerogatives set forth in Section 4.1.2.

(d) Practitioners appointed to the active Medical Staff category with emeritus-active designation must continue to fulfill the Medical Staff responsibilities set forth in Section 4.1.3 with the exception that such Practitioners are not required to pay Medical Staff dues (if any), application fees, or assessments.

4.2. COURTESY MEDICAL STAFF CATEGORY

4.2.1 Qualifications. Practitioners appointed to the courtesy Medical Staff category must:

(a) Meet the qualifications set forth in Section 3.2.

(b) Have not more than forty-nine (49) Patient Encounters at the Hospital each year (not including referrals to the Hospital's diagnostic facilities, access to which is unlimited).

(1) Appointees to the courtesy Medical Staff category that have more than forty-nine (49) Patient Encounters at the Hospital in a year may be considered for transfer to the active Medical Staff category.

4.2.2 Prerogatives. Practitioners appointed to the courtesy Medical Staff category may:

(a) Exercise the Privileges granted.

(b) Attend meetings of the Medical Staff and of the Medical Staff Department/Section and Medical Staff committees of which the Practitioner is a member.

(c) KH Dayton/Washington Township; KH Hamilton; KH Greene/Soin:

(1) Not vote on Medical Staff matters or on matters of the Department/Section and Medical Staff committees of which the Practitioner is a member.

(2) Not hold Medical Staff office.

(3) Not serve as a Medical Staff Department Chair or Department Vice Chair (if any) or Section Chair (if any).

(4) Not serve as a Medical Staff committee chair.

(d) KH Main/Miamisburg/Troy:

(1) Vote on Medical Staff matters and on matters of the Department/Section and Medical Staff committees of which the Practitioner is a member.

(2) Hold Medical Staff office subject to satisfaction of the applicable qualifications.

(3) Serve as a Medical Staff Department Chair or Department Vice Chair subject to satisfaction of the applicable qualifications.

(4) Serve as a Medical Staff committee chair subject to satisfaction of the applicable qualifications.

(e) Serve as a member of a Medical Staff committee subject to satisfaction of the applicable qualifications.

4.2.3 Responsibilities. Practitioners appointed to the courtesy Medical Staff category:

(a) Must:

(1) Satisfy the responsibilities set forth in Section 3.3.

(2) Timely respond to consultation requests.

(3) Participate in Hospital and Medical Staff education programs as appropriate.

(4) Discharge other Medical Staff functions as may be requested or required from time to time.

(5) Timely pay Medical Staff application fees, dues (if any), and assessments, as applicable.

(b) Are excused from the care of unassigned patients and from Emergency Call (unless there is a determination by the applicable Department Chair or Section Chair, Medical Executive Committee, Hospital administration and/or the Board that Practitioners appointed to the courtesy Medical Staff category granted certain Privileges in a particular Department or Section must participate in these responsibilities).

4.3. ASSOCIATE MEDICAL STAFF CATEGORY

4.3.1 Qualifications. Practitioners appointed to the associate Medical Staff category must:

(a) Meet the qualifications set forth in Section 3.2.2 (a), (d), (e), (h) and Section 3.2.3 (a), (d), (e), (g)-(i).

(b) Be a community-based Practitioner who desires to be associated with the Hospital but who does not provide patient care at the Hospital (or a provider-based location thereof).

4.3.2 Prerogatives. Practitioners appointed to the associate Medical Staff category may:

(a) Not be granted Privileges.

(b) Attend meetings of the Medical Staff and of the Medical Staff Department/Section and Medical Staff committees of which the Practitioner is a member.

(c) Vote on Medical Staff matters provided, however, that a Practitioner appointed to the associate Medical Staff category may not vote on whether to accept or reject (*i.e.,* opt-out of) a unified Medical Staff.

(d) Vote on matters of the Department/Section and Medical Staff committees of which the Practitioner is a member.

(e) Hold Medical Staff office subject to satisfaction of the applicable qualifications.

(f) KH Dayton/Washington Township and KH Main/Miamisburg/Troy: Serve as a Medical Staff Department Chair (*e.g.,* family medicine) or Department Vice Chair (if any) or Section Chair (if any) subject to satisfaction of the applicable qualifications.

(g) KH Hamilton and KH Greene/Soin: Not serve as a Medical Staff Department Chair or Department Vice Chair (if any) or Section Chair (if any).

(h) Serve as a Medical Staff committee chair subject to satisfaction of the applicable qualifications.

(i) Serve as a member of a Medical Staff committee subject to satisfaction of the applicable qualifications.

(j) May visit their patients when hospitalized and review such patients' medical records (provided the patient consents and subject to System/Hospital medical record/HIPAA policies). The Practitioner may not document in the Hospital medical record or participate in the provision or management of care, treatment, and/or services to patients at the Hospital (or a provider-based location thereof).

4.3.3 Responsibilities. Practitioners appointed to the associate Medical Staff category must:

(a) Satisfy the responsibilities set forth in Section 3.3 to the extent applicable to a Practitioner granted Medical Staff appointment without Privileges.

(b) Contribute to the administrative affairs of the Medical Staff.

(c) Participate in Hospital and Medical Staff education programs as appropriate.

(d) Faithfully perform the duties of any office or position to which elected or appointed.

(e) Serve on Medical Staff committees as assigned.

(f) Attend meetings of the Medical Staff, his/her Department and Section, and those committees on which he/she serves.

(g) Discharge such other Medical Staff functions (that do not require Privileges) as may be requested or required from time to time.

(h) Timely pay Medical Staff application fees, dues (if any), and assessments, as applicable.

4.4. RETIRED MEDICAL STAFF CATEGORY

4.4.1 Qualifications. Practitioners appointed to the retired Medical Staff category must:

(a) Meet the qualifications set forth in Section 3.2.2 (h) and Section 3.2.3 (a), (d), (e). (g), (i).

(b) Have retired from practice at the Hospital and requested to transfer to the retired Medical Staff category.

(c) Have been a Member of the Hospital Medical Staff with or without Privileges, in Good Standing, at the time of his/her retirement and continue to conduct himself/herself in a professional and ethical manner.

4.4.2 Prerogatives. Practitioners appointed to the retired Medical Staff category may:

(a) Not be granted Privileges.

(b) Attend meetings of the Medical Staff and of the Medical Staff Department/Section and Medical Staff committees of which the Practitioner is a member.

(c) KH Dayton/Washington Township; KH Hamilton; KH Greene/Soin:

(1) Vote on Medical Staff matters provided, however, that a Practitioner appointed to the retired Medical Staff category may not vote on whether to accept or reject (*i.e.,* opt-out of) a unified Medical Staff.

(2) Vote on matters of the Department/Section and Medical Staff committees of which the Practitioner is a member.

(d) KH Main/Miamisburg/Troy:

(1) Not vote on Medical Staff matters.

(2) Not vote on matters of the Department/Section

(3) Vote on matters of the Medical Staff committees of which the Practitioner is a member.

(e) Not hold Medical Staff office.

(f) Not serve as a Medical Staff Department Chair or Department Vice Chair (if any) or Section Chair (if any).

(g) Not serve as a Medical Staff committee chair.

(h) Serve as a member of a Medical Staff committee subject to satisfaction of the applicable qualifications.

4.4.3 Responsibilities. Practitioners appointed to the retired Medical Staff category:

(a) Must satisfy the responsibilities set forth in Section 3.3 to the extent applicable to a Practitioner granted Medical Staff appointment without Privileges.

(b) Are not subject to Medical Staff application fees, dues (if any), or assessments.

4.5. HONORARY MEDICAL STAFF CATEGORY

4.5.1 Qualifications. Practitioners appointed to the honorary Medical Staff category must:

(a) Meet the qualifications set forth in Section 3.2.2 (h) and Section 3.2.3 (a), (d), (e). (g), (i).

(b) Have retired from practice.

(c) Be deemed deserving of appointment to the honorary Medical Staff category by virtue of their outstanding reputation, noteworthy contributions to the health and medical sciences, and/or their previous longstanding service to the Hospital.

(d) Continue to exemplify high standards of professional conduct.

4.5.2 Prerogatives. Practitioners appointed to the honorary Medical Staff category may:

(a) Not be granted Privileges.

(b) Attend meetings of the Medical Staff and of the Medical Staff Department/Section and Medical Staff committees of which the Practitioner is a member.

(c) KH Dayton/Washington Township; KH Hamilton; KH Greene/Soin:

(1) Vote on Medical Staff matters provided, however, that a Practitioner appointed to the honorary Medical Staff category may not vote on whether to accept or reject (*i.e.,* opt-out of) a unified Medical Staff.

(2) Vote on matters of the Department/Section and Medical Staff committees of which the Practitioner is a member.

(d) KH Main/Miamisburg/Troy:

(1) Not vote on Medical Staff matters.

(2) Not vote on matters of the Department/Section

(3) Vote on matters of the Medical Staff committees of which the Practitioner is a member.

(e) Not hold Medical Staff office.

(f) Not serve as a Medical Staff Department Chair or Department Vice Chair (if any) or Section Chair (if any).

(g) Not serve as a Medical Staff committee chair.

(h) Serve as a member of a Medical Staff committee subject to satisfaction of the applicable qualifications.

4.5.3 Responsibilities. Practitioners appointed to the honorary Medical Staff category:

(a) Must satisfy the responsibilities set forth in Section 3.3 to the extent applicable to a Practitioner granted Medical Staff appointment without Privileges.

(b) Are not subject to Medical Staff application fees, dues (if any), or assessments.

ARTICLE 5
MEDICAL STAFF OFFICERS & MEC AT LARGE MEMBERS

5.1. DESIGNATION OF MEDICAL STAFF OFFICERS

5.1.1 The officers of the Medical Staff shall be the:

(a) Chief of Staff

(b) Vice Chief of Staff (Vice Chief of Staff/Elect)

(1) The KH Main/Miamisburg/Troy unified Medical Staff shall additionally have a Vice Chief of Staff/CQRC and a Vice Chief of Staff/Credentials.

(c) Immediate Past Chief of Staff

(d) Secretary/Treasurer

(1) This office is not applicable to the KH Main/Miamisburg/Troy unified Medical Staff.

5.2. QUALIFICATIONS OF MEDICAL STAFF OFFICERS & MEC AT LARGE MEMBERS

5.2.1 A Medical Staff officer must:

(a) Be a Physician or Podiatrist with the exception that the office of Secretary/Treasurer (if any) may be held by a Physician, Dentist, Podiatrist, or Psychologist.

(b) <u>KH Dayton/Washington Township; KH Hamilton; KH Greene/Soin</u>:

(1) Have and maintain, in Good Standing, a current appointment to the active Medical Staff category with Privileges or to the associate Medical Staff category without Privileges.

(2) Have been appointed to the active Medical Staff category with Privileges or to the associate Medical Staff category without Privileges for at least three (3) consecutive years prior to nomination unless this qualification is waived by the Medical Executive Committee

(c) <u>KH Main/Miamisburg/Troy</u>:

(1) Have and maintain, in Good Standing, a current appointment to the active or courtesy Medical Staff category with Privileges or to the associate Medical Staff category without Privileges.

(2) Have been appointed to the active or courtesy Medical Staff category with Privileges or to the associate Medical Staff category without Privileges for at least three (3) consecutive years prior to nomination unless this qualification is waived by the Medical Executive Committee.

(d) Have prior experience in a Medical Staff leadership position or equivalent (*e.g.,* have served as a Department Chair/Section Chair or committee chair or as a member of the MEC, *etc.*).

(e) Recognize and agree to the commitment of time needed to perform the duties associated with the office and participate in leadership education/training.

(f) Demonstrate the ability to communicate in a professional manner with colleagues, Hospital administration, and the Board.

(g) KH Dayton/Washington Township: Demonstrate a commitment to osteopathic practices and principles.

(h) Not have a disqualifying Conflict of Interest as further detailed in Sections 5.2.3, 5.2.4 and 5.3.2 (c).

5.2.2 MEC At Large Members [KH Dayton/Washington Township and KH Hamilton]

(a) Have and maintain, in Good Standing, a current appointment to the active Medical Staff category with Privileges or to the associate Medical Staff category without Privileges.

(b) Be willing and able to faithfully discharge the duties of the position.

(c) Not have a disqualifying Conflict of Interest as further detailed in Sections 5.2.3, 5.2.4 and 5.3.2 (c). The obligation to disclose Conflicts of Interest is an ongoing obligation of a Practitioner who is nominated for and/or who holds Medical Staff office or a MEC at large member position.

5.2.3 Medical Staff officers and MEC at large members may not simultaneously hold a leadership and/or board position at another hospital other than such position at an Affiliate Hospital.

5.2.4 Any Practitioner who is employed by or whose practice is owned/managed/operated by a competing hospital/healthcare entity (as determined by the Board or the Hospital President and/or Chief Medical Officer as authorized designees of the Board) is not eligible for Hospital Medical Staff leadership or Board positions, either elected or appointed, and is obligated to disclose such conflicting interests.

5.3. NOMINATION PROCESS

5.3.1 Nominating Committee. The composition of the Medical Staff Nominating Committee shall be set forth in the Medical Staff Organization Manual.

5.3.2 Nomination Process

(a) The Nominating Committee shall nominate qualified, eligible Practitioners for the office of the Vice Chief of Staff (Vice Chief of Staff/Elect) and the Secretary/Treasurer, as applicable.

(1) The Nominating Committee for the KH Main/Miamisburg/Troy unified Medical Staff shall additionally nominate qualified, eligible Practitioners for the offices of the Vice Chief of Staff/CQRC and the Vice Chief of Staff/Credentials.

(2) The Nominating Committee for the KH Dayton/Washington Township Medical Staff shall additionally nominate qualified, eligible Practitioners for the MEC at large member positions.

(3) The Nominating Committee for the KH Hamilton Medical Staff shall additionally nominate qualified eligible Practitioners for the MEC at large member positions.

(b) The Nominating Committee shall seek (in such manner as determined appropriate by the Nominating Committee) and consider nominations received from Medical Staff Appointees eligible to vote.

(c) All nominees for a Medical Staff office or a MEC at large member position shall, at the time of nomination, disclose to the Nominating Committee those personal, professional, or financial affiliations or relationships of which they are reasonably aware that could foreseeably result in a Conflict of Interest with their activities or responsibilities on behalf of the Medical Staff.

(1) In the event of such disclosure, the Hospital President and/or Chief Medical Officer (as authorized designees of the Board) will determine whether the Practitioner is eligible for Medical Staff office or a MEC at-large member position.

(2) If a Practitioner with a Conflict of Interest is determined to be eligible for office or a MEC at large member position, the Conflict of Interest disclosure will be provided to the Medical Staff when the approved nominations are communicated.

(d) Nominees for the offices of Vice Chief of Staff (Vice Chief of Staff/Elect), Secretary/Treasurer, and for the KH Dayton/Washington Township MEC at large member positions shall be subject to approval by the Medical Executive Committee. If the Medical Executive Committee does not approve a nominee, the Medical Executive Committee shall advise the

Nominating Committee and the committee shall select a replacement nominee who shall also be subject to approval by the Medical Executive Committee.

(e) The nominations for Vice Chief of Staff (Vice Chief of Staff/Elect), Secretary/Treasurer, and the KH Dayton/Washington Township MEC at large member positions shall be communicated to the Medical Staff prior to the election in such manner as determined appropriate by the Nominating Committee.

5.4. ELECTION OF DESIGNATED MEDICAL STAFF OFFICERS

5.4.1 The Vice Chief of Staff (Vice Chief of Staff/Elect) and Secretary/Treasurer shall be elected in one of the following ways at the discretion of the Medical Executive Committee:

(a) By a majority vote of the Medical Staff Appointees eligible to vote who are present at a Medical Staff meeting at which a quorum is present.

OR

(b) By ballot without a Medical Staff meeting. In such event, ballots shall be distributed to each Medical Staff Appointee eligible to vote. Ballots may be distributed electronically or in such other manner as determined appropriate by the Medical Executive Committee. Completed ballots must be returned within the time-period specified and according to the instructions that accompany the ballot. Ballots received after the stipulated date shall not be counted. The candidate who receives a majority vote of the total ballots returned by the stipulated date shall be elected.

5.4.2 If there are more than two (2) nominees for the same office/position and no nominee receives a majority of the votes cast on the first ballot, there shall be a run-off election between the two (2) nominees receiving the highest number of votes.

5.4.3 The KH Main/Miamisburg/Troy unified Medical Staff election for the offices of Vice Chief of Staff/CQRC and Vice Chief of Staff/Credentials shall follow the procedure set forth in Sections 5.4.1 and 5.4.2.

5.5. ELECTION OR APPOINTMENT OF MEC AT LARGE MEMBERS

5.5.1 The KH Dayton/Washington Township MEC at large members shall be elected in the same manner as set forth in Sections 5.4.1 and 5.4.2 for Medical Staff officers.

5.5.2 The KH Hamilton MEC at large members shall be appointed by the Chief of Staff at the direction of the voting members of the MEC.

5.6. AUTOMATIC SUCCESSION OF DESIGNATED MEDICAL STAFF OFFICERS

5.6.1 The Vice Chief of Staff (Vice Chief of Staff/Elect) shall automatically succeed to the office of Chief of Staff upon completion of his/her term as Vice Chief of Staff (Vice Chief of Staff/Elect).

5.6.2 The Chief of Staff shall automatically succeed to the office of Immediate Past Chief of Staff upon completion of his/her term as Chief of Staff.

5.7. TERM OF MEDICAL STAFF OFFICE & MEC AT LARGE MEMBERS

5.7.1 Each Medical Staff officer and MEC at large member will serve a term of two (2) years.

5.7.2 Each Medical Staff officer and MEC at large member shall serve until the end of his/her term, and until a successor is selected, unless the Medical Staff officer or MEC at large member sooner resigns or is removed from the office/position.

5.7.3 The number of consecutive two (2) year terms a Practitioner may be reelected to serve as Secretary/Treasurer shall be limited to three (3) terms.

5.7.4 A Practitioner elected to the office of Vice Chief of Staff/Credentials or Vice Chief of Staff/CQRC for the KH Main/Miamisburg/Troy unified Medical Staff may be reelected to serve consecutive two (2) year terms.

5.7.5 A Practitioner elected or appointed to serve as a MEC at large member may be reelected or reappointed to such position for consecutive two (2) year terms.

5.8. VACANCIES IN MEDICAL STAFF OFFICE OR IN A MEC AT LARGE MEMBER POSITION

5.8.1 In the office of Secretary/Treasurer. In the event of a vacancy in the office of the Secretary/Treasurer, the Medical Executive Committee will appoint a qualified Practitioner to serve as interim Secretary/Treasurer for the remainder of the current term after which an election for a new Secretary/Treasurer will be held in accordance with the procedure set forth in Sections 5.3 and 5.4. The Practitioner appointed by the MEC to complete the stub term may thereafter run for election.

5.8.2 In the office of Chief of Staff. In the event of a vacancy in the office of the Chief of Staff, the Vice Chief of Staff (Vice Chief of Staff/Elect) shall become Chief of Staff for the remainder of the current term. The Practitioner may continue to serve as Chief of Staff for the next succeeding two (2) year term or automatically succeed to the office of Immediate Past Chief of Staff following completion of the stub term at the discretion of the MEC.

5.8.3 In the office of Vice Chief of Staff (Vice Chief of Staff/Elect). In the event of a vacancy in the office of Vice Chief of Staff (Vice Chief of Staff/Elect), a special election shall be conducted as soon as reasonably possible, in accordance with the procedure set forth in Sections 5.3 and 5.4 to fill the vacancy for the remainder of the current term. The Practitioner elected may continue to serve as Vice Chief of

Staff (Vice Chief of Staff/Elect) for the next succeeding two (2) year term or automatically succeed to the office of Chief of Staff following completion of the stub term at the discretion of the MEC.

5.8.4 In the office of Immediate Past Chief of Staff. In the event of a vacancy in the office of the Immediate Past Chief of Staff, the Medical Executive Committee may either elect to leave the position vacant or to appoint a former Chief of Staff to fill the vacancy for the remainder of the current term and until the current Chief of Staff automatically succeeds to the office of Immediate Past Chief of Staff.

5.8.5 In the office of Vice Chief of Staff/Credentials or Vice Chief of Staff/CQRC (for the KH Main/Miamisburg/Troy unified Medical Staff). In the event of a vacancy in the office of the Vice Chief of Staff/Credentials or Vice Chief of Staff/CQRC for the KH Main/Miamisburg/Troy unified Medical Staff, the Medical Executive Committee will appoint a qualified Practitioner to serve as interim Vice Chief of Staff/Credentials or Vice Chief of Staff/CQRC for the remainder of the current term after which an election for a new Vice Chief of Staff/Credentials or Vice Chief of Staff CQRC will be held in accordance with the procedure set forth in Sections 5.3 and 5.4. The individual appointed by the MEC to complete the stub term may thereafter run for election.

5.8.6 In a KH Dayton/Washington Township MEC At Large Member Position. In the event of a vacancy in a MEC at large member position, the Medical Executive Committee will appoint a qualified Practitioner to serve as an interim MEC at large member for the remainder of the current term after which an election for a new MEC at large member will be held in accordance with the procedure set forth in Sections 5.3 and 5.4. The Practitioner appointed by the MEC to complete the stub term may thereafter run for election.

5.8.7 In a KH Hamilton MEC At Large Member Position. A vacancy in a MEC at large member position shall be filled in the same manner in which the original appointment was made.

5.9. RESIGNATION FROM MEDICAL STAFF OFFICE OR MEC AT LARGE MEMBER POSITION

5.9.1 Notice of Resignation. A Medical Staff officer or MEC at large member may resign at any time by giving written notice to the Medical Executive Committee.

5.9.2 Effective Date. Such resignation shall take effect on the date specified in the resignation notice or as of such other date as agreed upon by the resigning Medical Staff officer or MEC at large member and the Medical Executive Committee.

5.10. REMOVAL FROM MEDICAL STAFF OFFICE OR MEC AT LARGE MEMBER POSITION

5.10.1 Request for Removal

(a) A request for removal of a Medical Staff officer or a KH Dayton/ Washington Township MEC at large member must be made in writing by the Board, the MEC, or twenty-five percent (25%) of the Appointees who are eligible to vote and delivered to Medical Staff Services.

(b) The written request for removal shall state the basis for the request and shall be signed by the Board member(s), the KH Dayton/Washington Township MEC member(s), or the Medical Staff Appointees requesting removal.

(c) Medical Staff Services shall deliver a copy of the written request to the Medical Staff officer or KH Dayton/Washington Township MEC at large member by Special Notice.

(d) Within thirty (30) days after receiving a written request for removal of a Medical Staff officer or KH Dayton/Washington Township MEC at large member, a special meeting of the Medical Staff shall be held. Prior written notice of the special Medical Staff meeting at which a removal vote will be taken shall be provided to those individuals entitled to attend the meeting.

5.10.2 Action to Remove

(a) Removal of a Medical Staff officer or KH Dayton/Washington Township MEC at large member requires:

(1) A two-thirds (2/3rd) vote in favor of removal by those Medical Staff Appointees entitled to vote who are in attendance at the special Medical Staff meeting at which a quorum is present.

AND

(2) Ratification by the voting members of the Medical Executive Committee and Board.

(b) The Medical Staff officer or KH Dayton/Washington Township MEC at large member subject to removal shall be given an opportunity to speak on his/her own behalf at the meeting prior to such vote.

(c) Medical Staff Members eligible to vote shall vote by secret written ballot at such meeting.

5.10.3 Permissible Grounds for Removal. Permissible grounds for removal of a Medical Staff officer or MEC at large member include, but are not limited to:

(a) Failure to continuously satisfy the qualifications for the office/position.

(b) Failure to perform the duties of the office/position in a timely and appropriate manner.

(c) Inability to fulfill the duties of the office/position.

(d) Imposition of a summary suspension, an automatic suspension (other than for delinquent medical records), or corrective action undertaken against the Practitioner that results in a final Adverse decision.

5.10.4 Grounds for Automatic Removal

(a) Automatic termination of Medical Staff appointment and/or Privileges shall result in automatic removal of a Practitioner from his/her Medical Staff office or MEC at large member position.

(b) Automatic removal of a Practitioner from his/her Medical Staff office or MEC at large member position shall also occur as a result of a disqualifying Conflict of Interest that arises while in office or while serving as a MEC at large member.

5.10.5 Removal of a KH Hamilton MEC At Large Member. A KH Hamilton MEC at large member may be removed from his/her position:

(a) Based upon the grounds set forth in Section 5.10.3 by the Chief of Staff at the direction of the voting members of the MEC; or

(b) Automatically based upon the granted set forth in Section 5.10.4.

5.11. DUTIES OF MEDICAL STAFF OFFICERS

5.11.1 Chief of Staff. The Chief of Staff shall:

(a) Provide overall leadership and guidance to the Medical Staff.

(b) Serve as the chief administrative officer of the Medical Staff and act on behalf of the Medical Staff in coordination and cooperation with the Chief Medical Officer and Hospital President in matters of mutual concern involving the Hospital.

(c) Serve as a voting member and chair of the Medical Executive Committee and as a voting or *Ex Officio* (non-voting) member of such other Medical Staff committees as provided in the Medical Staff Organization Manual.

(d) Promote effective communications among the Medical Staff, Medical Executive Committee, Hospital administration, and the Board.

(e) Be responsible for:

(1) Implementation and enforcement of the Medical Staff governing documents.

(2) Medical Staff involvement in maintaining Hospital accreditation.

(3) Providing/communicating information to the Board concerning matters that pertain to the quality of care and treatment of patients at the Hospital.

(4) Facilitate positive relationships among Hospital administration, the Medical Staff, and Hospital staff/support services.

(5) The organization and conduct of the Medical Staff.

(f) Meet with the Board periodically throughout the calendar year (but at least twice per year) in a manner that permits immediate synchronous communication to discuss matters related to the quality of medical care provided to Hospital patients.

(g) Facilitates periodic review of the Medical Staff Bylaws, Manuals/Policies, and Rules & Regulations, at least every three (3) years, or as otherwise required by applicable accreditation standards.

(h) Call, preside at, and be responsible for the agenda of all Medical Staff meetings.

(i) Represent the views, policies, needs and concerns of the Medical Staff to the Chief Medical Officer, Hospital President and Board.

(j) Perform such other duties as set forth in the Medical Staff governing documents.

5.11.2 Vice Chief of Staff (Vice Chief of Staff/Elect). The Vice Chief of Staff (Vice Chief of Staff/Elect) shall:

(a) Provide continuity in leadership during times when the Chief of Staff is absent or otherwise unable to perform his/her assigned functions.

(b) In the absence of the Chief of Staff, assume the duties and have the authority of the Chief of Staff.

(c) Be expected to remain knowledgeable about Medical Staff issues of current Medical Staff interest.

(d) Serve as a voting member of the MEC and as a voting or *Ex Officio* (non-voting) member of such other Medical Staff committees as provided in the Medical Staff Organization Manual.

(e) Perform such other duties as assigned by the Chief of Staff and/or as set forth in the Medical Staff governing documents.

5.11.3 Immediate Past Chief of Staff. The Immediate Past Chief of Staff shall:

(a) Serve as a voting member of the MEC and as a voting or *Ex Officio* (non-voting) member of such other Medical Staff committees as provided in the Medical Staff Organization Manual.

(b) For purposes of the KH Main/Miamisburg/Troy Medical Staff: If/when necessary, assume the duties and responsibilities of the Chief of Staff during the simultaneous temporary absence/unavailability of the Chief of Staff and the Vice Chief of Staff (Vice Chief of Staff/Elect) until such absence/unavailability is ended.

(c) Perform such other duties as assigned by the Chief of Staff and/or as set forth in the Medical Staff governing documents.

5.11.4 Secretary/Treasurer (if applicable). The Secretary/Treasurer shall:

(a) Serve as a voting member of the MEC and as a voting or *Ex Officio* (non-voting) member of such other Medical Staff committees as provided in the Medical Staff Organization Manual.

(b) With the assistance of Hospital administrative support personnel:

(1) Give proper notice of all Medical Staff meetings.

(2) Record or cause to be recorded minutes of all meetings of the Medical Staff and the Medical Executive Committee.

(3) Oversee collection of annual dues and the keeping of accurate accounts of Medical Staff funds, where applicable.

(4) Oversee the financial obligations of the Medical Staff, if any.

(5) Submit the books of the Medical Staff as/when necessary for accounting review and/or audit as directed by the Medical Executive Committee.

(c) Perform such other duties as assigned by the Chief of Staff and/or as set forth in the Medical Staff governing documents.

(d) For purposes of the KH Greene/Soin unified Medical Staff; KH Hamilton, and KH Dayton/Washington Township: If/when necessary, assume the duties and responsibilities of the Chief of Staff during the simultaneous temporary absence/unavailability of the Chief of Staff and the Vice Chief of Staff (Vice Chief of Staff/Elect) until such absence/unavailability is ended.

5.11.5 Vice Chief of Staff Credentials (for the KH Main/Miamisburg/Troy unified Medical Staff). The Vice Chief of Staff/Credentials shall:

(a) Serve as a voting member of the MEC and as a voting or *Ex Officio* (non-voting) member of such other Medical Staff committees as provided in the Medical Staff Organization Manual.

(b) Chair the Medical Staff Credentials Committee and oversee implementation of the applicable procedures set forth in the Medical Staff governing documents for credentialing, appointment/reappointment, and privileging.

(c) Perform such other duties as assigned by the Chief of Staff and/or as set forth in the Medical Staff governing documents.

5.11.6 Vice Chief of Staff/CQRC (for the KH Main/Miamisburg/Troy unified Medical Staff). The Vice Chief of Staff/CQRC shall:

(a) Perform the functions of a Medical Staff secretary/treasurer.

(b) Serve as a voting member of the MEC and as a voting or *Ex Officio* (non-voting) member of such other Medical Staff committees as provided in the Medical Staff Organization Manual.

(c) Chair the Clinical Quality Review Committee, oversee implementation of the procedure set forth in the Practitioner/APP Peer Review Policy, and report aggregate data to the Quality Assurance and Performance Improvement Committee.

(d) Perform such other duties as assigned by the Chief of Staff and/or as set forth in the Medical Staff governing documents.

5.12. MEDICAL STAFF MEETINGS

5.12.1 Requirements with respect to meetings of the Medical Staff (including, but not limited to notice, quorum, manner of action, *etc.*) are set forth in the Medical Staff Organization Manual.

ARTICLE 6
MEDICAL STAFF DEPARTMENTS AND SECTIONS

6.1. STRUCTURE

6.1.1 The Medical Staff is organized as a departmentalized Medical Staff with certain Departments being comprised of specialty Sections.

6.1.2 Medical Staff Departments and Sections may be established, renamed, combined, or eliminated by action of the Board after consultation with and a recommendation from the MEC. A Medical Staff Department/Section shall have no fewer than three (3) Practitioners appointed to the active Medical Staff category with Privileges in a specialty within the Department or Section.

6.1.3 A list of Medical Staff Departments and Sections is set forth in the Medical Staff Organization Manual.

6.1.4 Each Department and Section shall have a chair as further described in this Article.

6.1.5 Each Practitioner shall be assigned to the Medical Staff Department and Section that most clearly reflects his/her professional training and experience in the clinical area in which his/her practice is concentrated.

6.2. MEDICAL STAFF DEPARTMENT CHAIR QUALIFICATIONS

6.2.1 Each Medical Staff Department shall have a Department Chair that meets the following qualifications:

(a) <u>KH Hamilton and KH Greene/Soin</u>

(1) Be a Physician

(2) Have and maintain, in Good Standing, a current appointment to the active Medical Staff category with Privileges in the Department.

(3) Have been appointed to the active Medical Staff category and exercised Privileges at the Hospital for at least three (3) consecutive years prior to nomination unless this qualification is waived by the MEC.

(b) <u>KH Dayton/Washington Township</u>

(1) Be a Physician

(2) Have and maintain, in Good Standing, a current appointment to the active Medical Staff category with Privileges in the Department or to the associate Medical Staff category without Privileges (for purposes of the Department of Family Medicine).

(3) Have been appointed to the active Medical Staff category and exercised Privileges at the Hospital or to the associate Medical Staff category without Privileges (for purposes of the Department of Family Medicine) for at least three (3) consecutive years prior to nomination unless this qualification is waived by the MEC.

(c) KH Main/Miamisburg/Troy

(1) Be a Physician, Dentist, or Podiatrist

(2) Have and maintain, in Good Standing, a current appointment to the active or courtesy Medical Staff category with Privileges in the Department or to the associate Medical Staff category without Privileges (for purposes of the Department of Family Medicine).

(3) Have been appointed to the active or courtesy Medical Staff category and exercised Privileges at the Hospital or to the associate Medical Staff category without Privileges (for purposes of the Department of Family Medicine) for at least three (3) consecutive years prior to nomination unless this qualification is waived by the MEC.

(d) Be qualified by training, practical experience in the specific area of medicine within the Medical Staff Department, and administrative ability for the position.

(e) Be willing and able to faithfully discharge the duties of the position.

(f) Not have a disqualifying Conflict of Interest as further detailed in Sections 6.2.2, 6.2.3, and 6.3.2. The obligation to disclose Conflicts of Interest is an ongoing obligation of a Practitioner who is nominated for and/or who holds a Department Chair position.

6.2.2 Department Chairs may not simultaneously hold a leadership and/or board position at another competing hospital other than such position at an Affiliate Hospital.

6.2.3 In order to avoid a conflicting interest, any Practitioner who is employed by or whose practice is owned/managed/operated by a competing hospital/healthcare entity (as determined by the Board or the Hospital President and/or Chief Medical Officer as authorized designees of the Board) is not eligible for Hospital Medical Staff leadership or Board positions, either elected or appointed, and is obligated to disclose such conflicting interests.

6.3. NOMINATION & ELECTION OF DEPARTMENT CHAIRS

6.3.1 The procedure for nomination and election of Departments Chairs set forth in Section 6.3 shall be followed unless otherwise provided in an applicable professional services agreement for a contracted Department Chair.

6.3.2 Prior to completion of his/her term as Department Chair, the current chair will issue a communication (in such manner as deemed appropriate) calling for nominations. Nominations received from Department members eligible to vote on Department matters will be considered.

(a) All nominees for a Department Chair position shall, at the time of nomination, disclose to the Medical Executive Committee those personal, professional, or financial affiliations or relationships of which they are reasonably aware that could foreseeably result in a Conflict of Interest with their activities or responsibilities on behalf of the Medical Staff.

(b) In the event of such disclosure, the Hospital President and/or Chief Medical Officer (as authorized designees of the Board) will determine whether the Practitioner is eligible to run for a Department Chair position.

(c) If a Practitioner with a Conflict of Interest is determined to be eligible to run for a Department Chair position, the Conflict of Interest disclosure will be provided to the Medical Staff Department members when the approved nominations are communicated.

6.3.3 KH Hamilton: The KH Hamilton MEC will approve nominees for elected Department Chair positions prior to holding an election.

6.3.4 Department Chairs will be elected in one of the following ways at the discretion of the current Department Chair:

(a) By a majority vote of the Medical Staff Department members eligible to vote who are present at a Department meeting at which a quorum is present.

OR

(b) By ballot without a Medical Staff Department meeting. In such event, ballots shall be distributed to each Department member eligible to vote. Ballots may be distributed electronically or in such other manner as determined appropriate by the current Department Chair. Completed ballots must be returned within the time-period specified and according to the instructions that accompany the ballot. Ballots received after the stipulated date shall not be counted. The candidate who receives a majority vote of the total ballots returned by the stipulated date shall be elected.

6.3.5 If there are more than two (2) nominees for the same office and no nominee receives a majority of the votes cast on the first ballot, there shall be a run-off election between the two (2) nominees receiving the highest number of votes.

6.4. TERM OF DEPARTMENT CHAIRS

6.4.1 Unless otherwise provided in an applicable professional services agreement for a contracted Department Chair:

(a) Department Chairs shall serve a two (2) year term.

(b) Each Department Chair shall serve until the end of his/her term, and until a successor is selected, unless the Department Chair sooner resigns or is removed from the position.

(c) Department Chairs are eligible to serve additional consecutive terms with the exception that KH Hamilton Department Chairs may serve no more than three (3) consecutive terms unless otherwise approved by the MEC.

6.5. VACANCY

6.5.1 Unless otherwise provided in an applicable professional services agreement for a contracted Department Chair, a vacancy in a Department Chair position will be filled in one of the following ways at the discretion of the MEC:

(a) By election in the manner set forth in Section 6.3.

OR

(b) In the event the Department has a Department Vice Chair, the Department Vice Chair may serve as the interim Department Chair for the remainder of the current term and is eligible for nomination as a candidate for election as the new Department Chair following completion of the stub term.

6.6. RESIGNATION OF DEPARTMENT CHAIRS

6.6.1 Unless otherwise provided in an applicable professional services agreement for a contracted Department Chair:

(a) Medical Staff Department Chairs may resign at any time by giving written notice to the MEC.

(b) Such resignation shall take effect on the date specified in the resignation notice or as of such other date as agreed upon by the resigning Department Chair and the Medical Executive Committee

6.7. REMOVAL OF DEPARTMENT CHAIRS

6.7.1 The procedure for removal of Departments Chairs set forth in Section 6.7 shall be followed unless otherwise provided in an applicable professional services agreement for a contracted Department Chair.

6.7.2 Request for Removal

(a) A request for removal of a Medical Staff Department Chair must be made in writing by the MEC or a majority of the Department members who are eligible to vote and delivered to Medical Staff Services.

(b) The written request for removal shall state the basis for the request and shall be signed by the MEC member(s) or the Medical Staff Department members requesting removal.

(c) Medical Staff Services shall deliver a copy of the written request to the Medical Staff Department Chair by Special Notice.

(d) Within thirty (30) days after receiving a written request for removal of a Medical Staff Department Chair, a special meeting of the MEC or the Medical Staff Department shall be held. Prior written notice of the special MEC or Medical Staff Department meeting at which a removal vote will be taken shall be provided to those individuals entitled to attend the meeting.

6.7.3 Action to Remove

(a) Removal of a Medical Staff Department Chair requires:

(1) A majority vote in favor of removal by those MEC members entitled to vote who are in attendance at the special MEC meeting at which a quorum is present subject to ratification of removal by the Board.

OR

(2) A two-thirds (2/3rd) vote in favor of removal by those Medical Staff Department members entitled to vote who are in attendance at the special Medical Staff Department meeting at which a quorum is present subject to ratification of removal by the MEC and the Board.

(b) The Medical Staff officer subject to removal shall be given an opportunity to speak on his/her own behalf at the MEC meeting or Medical Staff Department meeting prior to such vote.

(c) The vote shall be taken by secret written ballot at the MEC meeting or Medical Staff Department meeting.

6.7.4 Permissible Grounds for Removal. Permissible grounds for removal of a Medical Staff Department Chair include, but are not limited to:

(a) Failure to continuously satisfy the qualifications for the position.

(b) Failure to perform the duties of the position in a timely and appropriate manner.

(c) Inability to fulfill the duties of the position.

(d) Imposition of a summary suspension, an automatic suspension (other than for delinquent medical records), or corrective action undertaken against the Practitioner that results in a final Adverse decision.

6.7.5 Grounds for Automatic Removal

(a) Automatic termination of Medical Staff appointment and/or Privileges shall result in automatic removal of a Practitioner from his/her Medical Staff Department Chair position.

(b) Automatic removal of a Practitioner from his/her Department Chair position shall also occur as a result of a disqualifying Conflict of Interest that arises while serving as a Department Chair.

6.8. DEPARTMENT CHAIR DUTIES

6.8.1 Each Department Chair shall:

(a) Be responsible for the organization of all Medical Staff activities of the Department and for the general administration of the Department.

(b) Attend meetings of the Medical Executive Committee to provide input/guidance on the overall medical policies of the Hospital and to make specific recommendations and suggestions regarding the Department in order to assure quality patient care.

(c) Review applications and transmit to the Credentials Committee the Department Chair's recommendations concerning Medical Staff appointment, reappointment, and/or Privileges.

(d) Review the professional performance of all Practitioners and APPs with Privileges in the Department and report and recommend thereon to the Credentials Committee as part of the process for regrant of Privileges and to other applicable Medical Staff committees at such other times as may be indicated.

(e) Be responsible for enforcement within the Department of the Medical Staff Bylaws, Manuals/Policies, Rules and Regulations and applicable System/Hospital policies/procedures.

(f) Be responsible for implementation within the Department of actions recommended by the MEC and approved/taken by the Hospital Board.

(g) Be responsible for the establishment, implementation, and effectiveness of teaching, education, and any research programs in the Department.

(h) Report and make recommendations to Hospital administration, when necessary, with respect to matters affecting patient care.

(i) Assist Hospital administration with preparation of annual reports and budget planning pertaining to the Department as may be requested by the CMO, the Hospital President, or the Board.

(j) Facilitate review of clinical policies and procedures that are pertinent to the Department.

(k) Perform such other duties with respect to the Department as provided by the Medical Staff governing documents or requested by the Chief of Staff.

6.9. DEPARTMENT VICE CHAIRS

6.9.1 Applicability. The Department Vice Chair position is:

(a) Not applicable to KH Dayton/Washington Township or KH Hamilton.

(b) Applicable to KH Main/Miamisburg/Troy.

(c) Optional for KH Greene/Soin at the discretion of the voting members of each Medical Staff Department.

6.9.2 Qualifications. A Department Vice Chair, if any, shall satisfy the same qualifications as set forth in Section 6.2 for Department Chairs.

6.9.3 Election. A Department Vice Chair, if any, shall be nominated and elected in the same manner as set forth in Section 6.3 for Department Chairs.

6.9.4 Term. A Department Vice Chair, if any, shall serve the same term as set forth in Section 6.4 for Department Chairs.

6.9.5 Vacancy. A vacancy in a Department Vice Chair position, if any, shall be filled in the same manner in which the original position was filled.

6.9.6 Resignation. A Department Vice Chair, if any, may resign in the same manner as set forth in Section 6.6 for Department Chairs.

6.9.7 Removal. A Department Vice Chair, if any, may be removed in the same manner as set forth in Section 6.7 for Department Chairs.

6.9.8 Duties. A Department Vice Chair, if any, shall:

(a) Fulfill the duties set forth in Section 6.8 for Department Chairs in the Department Chair's absence.

(b) Perform such other duties as requested by the Department Chair.

6.9.9 References. References to the "Department Chair" in Sections 6.2 through 6.8 shall be read as "Department Vice Chair" for purposes of this Section 6.9.

6.10. MEDICAL STAFF SECTION CHAIRS

6.10.1 Applicability. The Section Chair position is:

(a) Not applicable to KH Greene/Soin or KH Hamilton or KH Main/Miamisburg/Troy.

(b) Applicable to KH Dayton/Washington Township.

6.10.2 Qualifications. A Section Chair shall satisfy the same qualifications as set forth in Section 6.2 for Department Chairs.

6.10.3 Appointment. A Section Chair shall be nominated and elected by the voting members of the Section in the same manner as set forth in Section 6.3 for Department Chairs.

6.10.4 Term. A Section Chair shall serve the same term as set forth in Section 6.4 for Department Chairs.

6.10.5 Vacancy. A vacancy in a Section Chair position shall be filled in the same manner in which the original position was filled.

6.10.6 Resignation. A Section Chair may resign in the same manner as set forth in Section 6.6 for Department Chairs.

6.10.7 Removal. A Section Chair may be removed in the same manner as set forth in Section 6.7 for Department Chairs.

6.10.8 Duties. A Section Chair shall fulfill the same duties set forth in Section 6.8 for Department Chairs, as applicable to the Section. A Section Chair shall perform such additional duties as requested by the Department Chair.

6.10.9 References. References to the "Department" and "Department Chair" in Sections 6.2 through 6.8 shall be read as "Section" and "Section Chair" for purposes of this Section 6.10.

6.11. MEDICAL STAFF DEPARTMENT & SECTION MEETINGS

6.11.1 Requirements with respect to meetings of Medical Staff Departments and Sections (including, but not limited to notice, quorum, manner of action, *etc.*) are set forth in the Medical Staff Organization Manual.

ARTICLE 7
MEDICAL STAFF COMMITTEES

7.1. MEDICAL EXECUTIVE COMMITTEE (MEC)

7.1.1 Composition. The composition of the Medical Executive Committee shall be as set forth in:

(a) Addendum A for KH Dayton/Washington Township.

(b) Addendum B for KH Greene/Soin.

(c) Addendum C for KH Hamilton.

(d) Addendum D for KH Main/Miamisburg/Troy.

7.1.2 Eligibility. All Practitioners appointed to the active or associate Medical Staff category are eligible for membership on the Medical Executive Committee; however, the majority of voting members of the Medical Executive Committee shall, at all times, be Physicians appointed to the active Medical Staff category with Privileges at the Hospital.

(a) For purposes of KH Main/Miamisburg/Troy, Practitioners appointed to the courtesy Medical Staff category are also eligible to serve on the Medical Executive Committee.

(b) For purposes of KH Dayton/Washington Township, the majority of voting members of the Medical Executive Committee shall, at all times, be Doctors of Osteopathic Medicine who are appointed to the active Medical Staff category with Privileges at the Hospital.

7.1.3 Disqualifying Conflicts of Interest. Voting members of the Medical Executive Committee may not have a disqualifying Conflict of Interest.

(a) See Article 5 with respect to Medical Staff officers.

(b) See Article 6 with respect to Department Chairs and Section Chairs.

(c) KH Dayton/Washington Township and KH Hamilton: See Article 5 with respect to MEC at large members.

(d) KH Dayton/Washington Township: See Addendum A with respect to additional Department specific representatives (*i.e.,* Department representatives in addition to/other than the Department Chair).

7.1.4 MEC Chair. The Chief of Staff shall chair the MEC.

7.1.5 MEC Duties

(a) The duties of the Medical Executive Committee shall be to:

(1) Represent and act on behalf of the Medical Staff when the Medical Staff cannot be assembled or in the intervals between general Medical Staff meetings within the scope of the MEC's authority as provided for in the Medical Staff governing documents.

(2) Report at each general Medical Staff meeting.

(3) Receive and act upon reports and recommendations from Medical Staff committees, joint Hospital/Medical Staff committees, Medical Staff Departments/Sections, and assigned activity groups, and make recommendations to the Board regarding the same, including the following Quality Assurance/Performance Improvement (QA/PI) functions:

(i) Medication therapy, including antibiotics and non-antibiotics, for all patient service types.

(ii) Infection control including community acquired and healthcare acquired infections in patients and health care workers.

(iii) Surgical/invasive and manipulative procedures, including tissue and non-tissue producing cases, with or without anesthesia and/or moderate sedation.

(iv) Blood (including component) product usage.

(v) Data management (accuracy, currency, transferability) with emphasis on medical record pertinence and timeliness.

(vi) Discharge planning and utilization review.

(vii) Complaints regarding Medical Staff related issues.

(viii) Restraint/seclusion usage.

(ix) Mortality review.

(4) Make recommendations to the Board regarding:

(i) Medical Staff structure as set forth in the Medical Staff governing documents.

(ii) Appointments, reappointments, and privileging following review and consideration of each Practitioner's/APP's credentials.

(iii) The effect of proposed administrative actions on patient care upon request of the Hospital President including, but not limited to, exclusive contracts pursuant to Section 3.7.

(5) Oversee and monitor the professional, clinical, quality/performance improvement (including customer satisfaction and patient safety), peer review/professional practice evaluation activities of the Medical Staff to help create and maintain a culture of safety and quality throughout the Hospital.

(6) Act as a liaison between the Medical Staff and the Chief of Staff.

(7) Recommend action to the Chief of Staff on matters of a medico-administrative nature.

(8) Ensure that the Medical Staff is kept abreast of the accreditation program and informed of the accreditation and licensure status of the Hospital.

(9) Fulfill the Medical Staff's accountability to the Board for the medical care rendered to patients in the Hospital.

(10) Oversee the quality of patient care, treatment, and services provided by Practitioners and APPs granted Privileges at the Hospital.

(11) Request evaluation of a Practitioner or APP, through the appropriate Medical Staff process, in instances where there is doubt as to such individual's ability to perform the Privileges requested/granted.

(12) Take reasonable steps to assure ethical professional conduct and competent clinical performance on the part of Practitioners and APPs granted Privileges at the Hospital.

(13) Implement, as applicable, the Medical Staff procedure for corrective action, summary suspension, hearings/appeals, and/or automatic suspension/automatic termination of Medical Staff appointment and/or Privileges.

(14) Establish mechanisms to provide effective communication among the Medical Staff, Hospital administration, and the Board regarding policy decisions affecting patient care in the Hospital.

(15) Establish mechanisms by which residents and fellows in training are supervised by Medical Staff Appointees with appropriate Privileges.

(16) Access and recommend to the relevant Hospital authority off-site sources for needed patient care services not provided by the Hospital.

(17) Recommend the clinical services to be provided by telemedicine.

(18) Make recommendations to the Medical Staff for adoption and amendment of the Medical Staff Bylaws in accordance with the applicable procedure set forth in Article 12.

(19) Adopt and amend Medical Staff Manuals/Policies and Rules and Regulations subject to the applicable procedure set forth in Article 12.

(20) Implement and enforce the Medical Staff Bylaws, Manuals/Policies, and Rules and Regulations and applicable System/Hospital policies.

(21) Conduct such other functions as necessary for the effective operation of the Medical Staff.

(22) Perform such other duties as requested by the Medical Staff, as set forth in the Medical Staff governing documents, and/or pursuant to applicable accreditation standards.

7.1.6 Meetings, Reports, and Recommendations

(a) The Medical Executive Committee will meet at least eight (8) times a year and more frequently as determined by the MEC chair.

(b) Minutes of each MEC meeting shall be prepared and retained. Such minutes will include a record of attendance, agenda items, and actions (*e.g.,* voting). The minutes should include minutes of/reports from the various Departments, Sections, and committees of the Medical Staff.

(c) Actions of the Medical Executive Committee shall be reported to the Medical Staff as part of the Medical Executive Committee's report at each general Medical Staff meeting.

(d) Recommendations of the Medical Executive Committee shall be transmitted to the Board as appropriate.

(e) The MEC shall claim all privileges and immunities afforded to it under the law as a peer review committee and shall maintain the confidentiality of all peer review records and communications as privileged information.

7.2. OTHER STANDING MEDICAL STAFF COMMITTEES

7.2.1 Creation, Modification, or Elimination of Standing Medical Staff Committees

(a) Information with respect to standing Medical Staff committees (other than the MEC) is set forth in the Medical Staff Organization Manual.

(b) The Medical Executive Committee may create additional standing Medical Staff committees, modify a standing Medical Staff committee's composition, duties, or meeting requirements, or eliminate a standing Medical Staff committee by amending the Medical Staff Organization Manual.

7.2.2 Selection/Removal of Members/Chairs of Standing Medical Staff Committees & Requirements Regarding Meetings of Standing Medical Staff Committees

(a) The method of selecting and removing members and chairs of each standing Medical Staff committee is set forth in the Medical Staff Organization Manual with the exception of the Medical Executive Committee which is addressed in these Bylaws.

(b) Requirements with respect to meetings of standing Medical Staff committees (including, but not limited to, notice, quorum, manner of action, *etc.*) are set forth in the Medical Staff Organization Manual.

ARTICLE 8
UNIFIED AND INTEGRATED MEDICAL STAFF OPTION

8.1. IN GENERAL

8.1.1 The Hospital is part of a multi-hospital System. In the event a Medical Staff is required by its Board to vote to either accept a unified Medical Staff structure or to opt out of such a structure, the process to follow is as described in this Article.

8.2. VOTING TO ACCEPT OR REJECT A UNIFIED MEDICAL STAFF

8.2.1 A Medical Staff must initially vote to opt in or out of a unified Medical Staff by a majority vote that is consistent with the method for amending these Bylaws as set forth in Section 12.2.4; provided, however, that only Practitioners appointed to the active Medical Staff category who hold Privileges to practice on-site at the Hospital may vote on whether to accept or reject a unified Medical Staff.

8.3. UNIFIED MEDICAL STAFF GOVERNING DOCUMENTS

8.3.1 There shall be one set of Medical Staff governing documents applicable to a unified Medical Staff that reflects the unique needs, circumstances, patient populations, and services of the System Hospitals and Medical Staffs that elected a unified Medical Staff.

8.4. OPTING OUT

8.4.1 Should a Medical Staff elect to become part of a unified Medical Staff but at a later date wish to "opt out" of that relationship, a vote to opt out of such unified Medical Staff may be called consistent with the methodology for opting out set forth in the unified Medical Staff Credentials Manual then in effect.

8.4.2 The opt out decision may not be delegated to the executive committee of the unified Medical Staff.

8.4.3 Periodic notice of the right to opt out of a unified Medical Staff shall be provided in accordance with the process set forth in the unified Medical Staff Credentials Manual then in effect.

ARTICLE 9
PROCEDURE FOR CORRECTIVE ACTION & SUMMARY SUSPENSION; GROUNDS FOR AUTOMATIC SUSPENSION/AUTOMATIC TERMINATION

9.1. COLLEGIAL INTERVENTION/REMEDIATION

9.1.1 Concerns may arise from time to time regarding an Appointee's performance (*i.e.,* clinical competence or conduct) that, in the judgment of the Chief of Staff, Chief Medical Officer, and/or Appointee's Department Chair or Section Chair may be amenable to a collegial remediation process. When appropriate, this course of action should be the first consideration before recommending to the Medical Executive Committee that it consider initiation of a corrective action investigation regarding such concerns.

9.1.2 An appropriately designated Medical Staff peer review committee may enter into a voluntary remediation agreement with a Medical Staff Member, consistent with the applicable Medical Staff Policy (*i.e.,* professionalism, impairment, peer review), to address clinical competency or conduct concerns.

9.1.3 If the affected Medical Staff Member fails to abide by the terms of an agreed upon remediation agreement, the Member may be subject to the corrective action procedure set forth in Section 9.2.

9.1.4 Nothing in this Section shall be construed as obligating the Hospital or Medical Staff leadership to engage in collegial intervention or remediation prior to referring the matter for initiation of corrective action on the basis of a single incident.

9.1.5 A written record of any collegial intervention and/or remediation efforts will be prepared and maintained in the Medical Staff Member's confidential peer review/quality file.

9.2. CORRECTIVE ACTION PROCEDURE

9.2.1 Request for Initiation of Corrective Action

(a) Any of the following may request that corrective action be initiated:

(1) Medical Staff officer

(2) Chair of a Department or Section in which the Practitioner has Privileges

(3) MEC or any other standing Medical Staff committee (or chair thereof)

(4) Chief Medical Officer

(5) Hospital President

(6) Board (or chair thereof)

(b) All requests for corrective action shall be submitted to the Medical Executive Committee in writing which writing may be reflected in minutes. Such request must be supported by reference to the specific activities or conduct that constitute(s) the grounds for the request. In the event the request for corrective action is initiated by the Medical Executive Committee, it shall reflect the basis therefore in its minutes.

(c) The chair of the Medical Executive Committee shall promptly notify the Hospital President of all requests for corrective action and shall continue to keep him/her fully informed of all action taken in conjunction therewith.

9.2.2 Grounds for Corrective Action

(a) Corrective action may be taken whenever a Medical Staff Member engages in activities or exhibits conduct within or outside of the Hospital that is/are, or is/are reasonably likely to be:

(1) Contrary to the Medical Staff Bylaws, Manuals, Rules & Regulations or applicable System, Hospital, or Medical Staff policies or procedures.

(2) Detrimental to patient safety or to the quality or efficiency of patient care in the Hospital.

(3) Disruptive to Hospital operations.

(4) Damaging to the Medical Staff's or the Hospital's reputation.

(5) Below the applicable standard of care.

9.2.3 MEC Action Upon Receipt of a Request for Initiation of Corrective Action

(a) Upon receipt of a request for corrective action, the MEC shall act on the request.

(b) The MEC may:

(1) Determine that no corrective action is warranted and close the matter.

(2) Determine that no corrective action is warranted but remand the matter for collegial intervention or remediation consistent with the applicable Medical Staff Policy (*i.e.,* professionalism, impairment, peer review).

(3) Initiate a corrective action investigation.

9.2.4 Commencement of a Corrective Action Investigation

(a) A matter shall be deemed to be under investigation upon determination by the MEC to initiate a corrective action investigation.

(b) The affected Medical Staff Member shall be provided with written notice of a determination by the Medical Executive Committee to initiate a corrective action investigation.

9.2.5 Conducting a Corrective Action Investigation

(a) The MEC may conduct such investigation itself; assign this task to a Medical Staff officer, Department Chair, Section Chair, the Chief Medical Officer, or a standing or ad hoc Medical Staff committee; or may refer the matter to the Board for investigation and resolution.

(b) The Medical Executive Committee may reasonably rely upon the findings of all prior Hospital or Medical Staff committees without conducting further inquiry.

(c) The investigating individual/group will proceed with its investigation in a prompt manner. The investigative process may include, without limitation, a meeting with: the Medical Staff Member involved who may be given an opportunity to provide information in a manner and upon such terms as the investigating individual/group deems appropriate; the individual or group who made the request; and/or other individuals who may have knowledge of, or information relevant to, the events involved.

(d) This investigation process is not a "hearing" as that term is used in these Bylaws and does not entitle the Medical Staff Member to the procedural due process rights provided in Article 10.

(e) If the investigation is conducted by a group or individual other than the Medical Executive Committee or the Board, that group or individual shall submit a written report of its investigation, which may be reflected by minutes, to the Medical Executive Committee as soon as practical after its receipt of the assignment to investigate. The report should contain such detail as is necessary for the Medical Executive Committee to rely upon it including recommendations for appropriate corrective action, or no action at all, and the basis for such recommendations.

(f) The Medical Executive Committee may at any time in its discretion, and shall at the request of the Board, terminate the investigation process and proceed with action as provided below.

9.2.6 Medical Executive Committee Action

(a) As soon as practical following completion of its report (which may be reflected by minutes), or receipt of a report from the investigating individual or group, the Medical Executive Committee shall act upon the request for corrective action.

(b) The MEC's actions may include, without limitation, the following:

(1) A determination that no corrective action be taken.

(2) Issuance of a verbal or written warning or a letter of reprimand.

(3) Imposition of a focused professional practice evaluation period with retrospective review of cases and/or other review of professional practice or conduct but without requirement of prior or concurrent consultation or direct supervision.

(4) Imposition of prior or concurrent consultation or direct supervision or other form of focused professional practice evaluation that limits the Medical Staff Member's ability to continue to exercise previously exercised Privileges for a period of up to fourteen (14) days.

(5) Imposition of a suspension of all, or any part, of the Medical Staff Member's Privileges for a period up to fourteen (14) days.

(6) Other actions deemed appropriate under the circumstances that will result in a limitation or reduction of the Medical Staff Member's Privileges for a period up to fourteen (14) days.

(7) Recommendation of imposition of prior or concurrent consultation or direct supervision or other form of focused professional practice evaluation that limits the Medical Staff Member's ability to continue to exercise previously exercised Privileges for a period in excess of fourteen (14) days.

(8) Recommendation of a suspension of all, or any part, of a Medical Staff Member's Privileges for a period in excess of fourteen (14) days.

(9) Recommendation of other actions deemed appropriate under the circumstances that will result in a limitation or reduction of the Medical Staff Member's Privileges for a period in excess of fourteen (14) days.

(10) Recommendation of revocation of all, or any part, of the Medical Staff Member's Privileges.

9.2.7 Adverse Recommendation. When the Medical Executive Committee's recommendation is Adverse (as defined in these Bylaws) to the Medical Staff Member, the Chief of Staff shall inform the Member, by Special Notice, and the Member shall be entitled, upon timely and proper request, to the procedural due process rights contained in Article 10. The Chief of Staff shall then hold the Adverse recommendation in abeyance until the Medical Staff Member has exercised or waived the right to a hearing and appeal after which the final MEC recommendation, together with all accompanying information, shall be forwarded to the Board.

9.2.8 Referral/Failure by the Medical Executive Committee to Act. If the Medical Executive Committee (i) refers the matter to the Board; or (ii) fails to act on a request for corrective action within an appropriate time, as determined by the Board, the Board may proceed with its own investigation or determination as applicable to the circumstances. In the case of (ii), the Board shall make such determination after notifying the Medical Executive Committee of the Board's intent and allowing a reasonable period of time for response by the Medical Executive Committee:

(a) If the Board's decision is not Adverse to the Medical Staff Member the action shall be effective as its final decision and the Hospital President shall inform the Member of the Board's decision by Special Notice.

(b) If the Board's action is Adverse to the Medical Staff Member, the Hospital President shall inform the Member, by Special Notice, and the Member shall be entitled, upon timely and proper request, to the procedural due process rights set forth in Article 10.

9.2.9 The commencement of a corrective action investigation against a Medical Staff Member shall not preclude the summary suspension or automatic suspension or automatic termination of Medical Staff appointment and/or all, or any portion, of the Member's Privileges in accordance with the applicable procedures set forth in this Article.

9.3. SUMMARY SUSPENSION PROCEDURE

9.3.1 Grounds for Summary Suspension & Authority to Impose. Whenever a Practitioner's conduct is of such a nature as to require immediate action to protect, or to reduce the substantial likelihood of injury or imminent danger to the life, health, or safety of any individual at the Hospital (*e.g.,* patient, employee, visitor, *etc.*), any of the following have the authority to summarily suspend the Medical Staff appointment and/or all, or any portion, of the Privileges of such Practitioner:

(a) Chief of Staff

(b) Department Chair (with approval of the Chief of Staff)

(c) Medical Executive Committee

(d) Hospital President or Chief Medical Officer (after conferring with the Chief of Staff)

(e) Board (or Board chair)

9.3.2 Process Following Imposition of a Summary Suspension

(a) A summary suspension is effective immediately.

(b) The person(s) or group imposing the summary suspension (if other than the Hospital President) shall immediately inform the Hospital President of the summary suspension and the Hospital President or the Chief of Staff shall promptly give Special Notice thereof to the Practitioner.

(c) The Chief of Staff or applicable Department Chair or Section Chair shall assign a suspended Practitioner's patients then in the Hospital to another Practitioner with appropriate Privileges considering the wishes of the patient where feasible.

(d) As soon as possible, but in no event later than five (5) days after a summary suspension is imposed, the Medical Executive Committee (if it did not impose the summary suspension) shall convene to review the matter and consider the need, if any, for a professional review action (*i.e.,* corrective action) pursuant to Section 9.2. Such a meeting of the Medical Executive Committee shall not be considered a "hearing" as contemplated in Article 10 (even if the involved Practitioner attends the meeting), and no procedural requirements shall apply.

(e) The Medical Executive Committee may modify, continue, or terminate a summary suspension provided that the summary suspension was not imposed by the Board.

(f) In the case of a summary suspension imposed by the Board, the Medical Executive Committee shall give its recommendation to the Board as to whether such summary suspension should be modified, continued, or terminated. The Board may accept, modify, or reject the Medical Executive Committee's recommendation.

(g) Not later than fourteen (14) days following the original imposition of the summary suspension, the Hospital President or the Chief of Staff shall notify the Practitioner, by Special Notice, of the Medical Executive Committee's determination; or, in the case of a summary suspension imposed by the Board, of the Medical Executive Committee's recommendation as to whether such summary suspension should be terminated, modified, or continued.

(1) If a summary suspension remains in place for more than fourteen (14) days the Practitioner shall be advised, by Special Notice, of the Practitioner's rights, if any, pursuant to Article 10.

(2) A summary suspension that is lifted within fourteen (14) days of its original imposition shall not be deemed an Adverse action for purposes of the procedural due process rights set forth in Article 10.

9.4. GROUNDS FOR AUTOMATIC SUSPENSION OR LIMITATION

9.4.1 Imposition of Automatic Suspension or Limitation

The following events shall result in an automatic suspension or limitation of Medical Staff appointment and/or Privileges without recourse to the procedural due process rights set forth in Article 10.

(a) Licensure

(1) Suspension. Action by any federal or state authority suspending a Practitioner's professional license shall result in an automatic suspension of the Practitioner's Medical Staff appointment and Privileges.

(2) Restriction. Whenever a Practitioner's professional license is limited, restricted, and/or made subject to probation, the Practitioner's Medical Staff appointment and Privileges shall automatically become subject to the same limitations, restrictions, and/or terms of the probation.

(3) Failure to Renew/Expired. Whenever a Practitioner's professional license expires solely as a result of the Practitioner's inadvertent failure to renew such license in a timely manner, the Practitioner's Medical Staff appointment and Privileges will be automatically suspended subject to Section 9.5.1 (b).

(b) Controlled Substance Authorization

If a DEA registration (or other authorization to prescribe controlled substances) is required for the Privileges granted:

(1) Suspension. Whenever a Practitioner's federal or state-controlled substance authorization (*e.g.,* DEA registration, *etc.*) is suspended, the Practitioner's Medical Staff appointment and Privileges shall be automatically suspended.

(2) Restriction. Whenever a Practitioner's federal or state-controlled substance authorization (*e.g.,* DEA registration, *etc.*) is limited, restricted, and/or made subject to probation, the Practitioner's right

to prescribe controlled substances shall automatically become subject to the same limitations, restrictions, and/or terms of the probation.

(3) Failure to Renew/Expired. Whenever a Practitioner's federal or state controlled substance authorization (*e.g.,* DEA registration, *etc.*) expires solely as a result of the Practitioner's inadvertent failure to renew such registration in a timely manner, the Practitioner's Medical Staff appointment and Privileges shall be automatically suspended subject to Section 9.5.2 (b).

(c) Professional Liability Insurance Coverage.

(1) If a Practitioner's Professional Liability Insurance coverage lapses, falls below the required minimum, is terminated, or otherwise ceases to be in effect, in whole or in part, the Practitioner's Medical Staff appointment and Privileges shall be automatically suspended until valid Professional Liability Insurance coverage is obtained (including any necessary gap coverage) and becomes effective or the matter is otherwise resolved pursuant to Section 9.5.3.

(2) The CCO and Medical Staff Services must be provided with proof of required coverage (*e.g.,* a certified copy of the insurance certificate from the insurance company) and a written statement from the Practitioner (i) explaining the circumstances of the Practitioner's non-compliance with the Hospital's Professional Liability Insurance requirements and any limitations on the new policy; and (ii) providing a summary of relevant activities, if any, during the period of non-compliance. For purposes of this section, the failure of a Practitioner to provide proof of Professional Liability Insurance shall constitute failure to meet the requirements of this provision.

(d) Federal Health Program. Whenever a Practitioner is suspended from participating in a Federal Health Program, the Practitioner's Medical Staff appointment and Privileges shall be automatically suspended. Voluntary non-participation (*i.e.,* "opt-out" subject to a granted waiver or as a result of a contract dispute with a managed care payor) is not grounds for automatic suspension.

(e) Failure to Pay Medical Staff Dues. Failure to pay Medical Staff dues within ninety (90) days after notice that such dues are due shall result in an automatic suspension of the Practitioner's Medical Staff appointment and Privileges until such time as the dues (and any fines) are paid. This ground is not applicable to KH Main/Miamisburg/Troy which does not charge Medical Staff dues.

(f) Immunizations, Vaccinations & Health Screenings. Failure to provide documentation of required immunizations, vaccinations, and/or health screenings (or an approved exemption therefrom) in accordance with the requirements set forth in the applicable System/Hospital/Medical Staff policies will result in an automatic suspension of the Practitioner's appointment and/or Privileges subject to Section 9.5.6 below.

(g) Failure to Complete Medical Records. Whenever a Practitioner fails to complete medical records in accordance with the applicable System/Hospital policy and/or Medical Staff Rules and Regulations, the Practitioner's Medical Staff appointment and/or Privileges shall be automatically suspended consistent with such policy and/or Medical Staff Rules and Regulations.

9.4.2 Impact of Automatic Suspension/Limitation

(a) During such period of time when a Practitioner's Medical Staff appointment and/or Privileges are automatically suspended or limited pursuant to Section 9.4.1 (a)-(f) he/she may not, as applicable, exercise Privileges at the Hospital or appointment Prerogatives.

(b) A Practitioner whose Privileges are automatically suspended pursuant to Section 9.4.1 (g) (*i.e.,* for delinquent medical records), is subject to the same limitations except that such Practitioner may:

(1) Conclude the management of any patient under his or her care in the Hospital at the time of the effective date of the automatic suspension.

(2) Attend to the management of any patient under his or her care whose admission or outpatient procedure was scheduled prior to the effective date of the automatic suspension.

9.4.3 Action Following Imposition of Automatic Suspension or Limitation

(a) As soon as practical after the imposition of an automatic suspension or limitation, the Medical Executive Committee shall convene, as necessary, to determine if corrective action is necessary in accordance with Section 9.2.

(b) Appropriate resolution on the part of the Practitioner with respect to the action or inaction that resulted in the automatic suspension (or limitation) of Medical Staff appointment and/or Privileges shall result in the automatic reinstatement of the Practitioner's Medical Staff appointment and/or Privileges.

(c) The Practitioner shall be obligated to provide such information as Medical Staff Services and the CCO request to assure that all information in the Practitioner's credentials file is current.

9.5. GROUNDS FOR AUTOMATIC TERMINATION

The following events shall result in an automatic termination of a Practitioner's Medical Staff appointment and Privileges without recourse to the procedural due process rights set forth in Article 10. The Practitioner may reapply for Medical Staff appointment and/or Privileges, as applicable, upon curing the issue(s) that gave rise to the automatic termination.

9.5.1 Licensure

(a) Revocation. Whenever a Practitioner's professional license to practice is revoked by the applicable licensing entity, his/her Medical Staff appointment and Privileges shall be automatically terminated.

(b) Expiration/Failure to Renew. Whenever a Practitioner (whose Medical Staff appointment and Privileges were automatically suspended pursuant to Section 9.4.1 (a)(3) for an expired license) fails to renew his/her license within ninety (90) days after its expiration, the Practitioner's Medical Staff appointment and Privileges shall be automatically terminated as of the ninety-first (91st) day.

9.5.2 Controlled Substance Authorization. If a DEA registration (or other authorization to prescribe controlled substances) is required for the Privileges granted:

(a) Revocation. Whenever a Practitioner's DEA registration (or other authorization to prescribe controlled substances) is revoked, his/her Medical Staff appointment and Privileges shall be automatically terminated.

(b) Expiration/Failure to Renew. Whenever a Practitioner (whose Medical Staff appointment and Privileges were automatically suspended pursuant to Section 9.4.1 (b)(3) for an expired DEA registration or other authorization to prescribe controlled substances) fails to renew his/her registration within ninety (90) days after its expiration, his/her Medical Staff appointment and Privileges shall be automatically terminated as of the ninety-first (91st) day.

9.5.3 Professional Liability Insurance. In conjunction with Section 9.4.1 (c), if a Practitioner's Professional Liability Insurance coverage lapses, falls below the required minimum, is terminated, or otherwise ceases to be in effect for a period greater than sixty (60) days, the Practitioner's Medical Staff appointment and Privileges shall automatically terminate as of the sixty-first (61st) day. For purposes of this provision, the failure of a Practitioner to provide proof of Professional Liability Insurance shall constitute a failure to meet the requirements of this provision.

9.5.4 Federal Health Program. Whenever a Practitioner is ineligible to participate in or is precluded/excluded from participating in a Federal Health Program, the Practitioner's Medical Staff appointment and Privileges shall be automatically terminated. Voluntary non-participation (*i.e.,* "opt-out" subject to a granted waiver or as a result of a contract dispute with a managed care payor) is not grounds for automatic termination.

9.5.5 Illegal Conduct. If a Practitioner pleads guilty to, or is found guilty of (i) a felony of any degree, or (ii) other serious offenses involving: violence or abuse upon a person; conversion, embezzlement, misappropriation of property; fraud; bribery; evidence tampering; perjury; drugs; or (iii) offenses that are considered contrary to community standards of justice, honesty or good morals, then the Practitioner's Medical Staff appointment and Privileges shall be automatically terminated.

9.5.6 Immunizations, Vaccinations & Health Screenings. In the event that documentation of required immunizations, vaccinations, and/or health screenings (or an approved exemption therefrom) is not provided within ninety (90) days following the date of an automatic suspension of Medical Staff appointment and/or Privileges pursuant to §9.4.1 (f), the Practitioner's Medical Staff appointment and/or Privileges shall automatically terminate as of the ninety-first (91st) day.

9.6. CONTINUITY OF PATIENT CARE

9.6.1 Upon the imposition of a summary suspension, an automatic suspension or limitation, or an automatic termination and in the event that the affected Practitioner's designed back-up/covering Practitioner (or another member of the Practitioner's group) is unable to assume care of the affected Practitioner's patients then in the Hospital, such patients will be assigned to another Practitioner(s) with appropriate Privileges by an officer of the Medical Staff or the applicable Department Chair/Section Chair.

9.6.2 The wishes of the patients should be considered in choosing a substitute Practitioner(s) when feasible.

9.6.3 The affected Practitioner shall confer with the substitute Practitioner(s) to the extent necessary to safeguard the patients.

9.7. CONSISTENCY OF ACTION

9.7.1 So that there is consistency between the Hospital and Affiliate Hospitals regarding corrective action and the status of medical staff appointment and privileges considering that the Hospital and the Affiliate Hospitals are part of the same healthcare System and that the Hospital and the Affiliate Hospitals have agreed to share information regarding appointment and/or privileges, the following automatic actions shall occur:

(a) With the exception of an automatic suspension for delinquent medical records or failure to pay Medical Staff dues (if applicable), if a Practitioner's

appointment and/or privileges are automatically suspended or automatically terminated, in whole or in part, at an Affiliate Hospital(s), the Practitioner's appointment and/or Privileges at this Hospital shall automatically become subject to the same action without recourse to the procedural due process rights set forth in Article 10.

(b) If a Practitioner's appointment and/or privileges are summarily suspended or if a Practitioner voluntarily agrees not to exercise privileges while undergoing an investigation at an Affiliate Hospital(s), such summary suspension or voluntary agreement not to exercise privileges shall automatically and equally apply to the Practitioner's appointment and/or Privileges at this Hospital, without recourse to the procedural due process rights set forth in Article 10, and shall remain in effect until such time as the Affiliate Hospital(s) render(s) a final decision or otherwise terminate(s) the process.

(c) If a Practitioner's appointment and/or privileges are limited, suspended, or terminated at an Affiliate Hospital(s), in whole or in part, based on professional conduct or clinical competency concerns, the Practitioner's appointment and/or Privileges at this Hospital shall automatically and immediately become subject to the same decision without recourse to the procedural due process rights set forth in Article 10 unless otherwise provided in the final decision at the Affiliate Hospital(s).

(d) If a Practitioner resigns his/her medical staff appointment and/or privileges or fails to seek reappointment and/or regrant of Privileges at an Affiliate Hospital(s) while under investigation or to avoid investigation for professional conduct or clinical competency concerns, such resignation shall automatically and equally apply to the Practitioner's Medical Staff appointment and/or Privileges at this Hospital without recourse to the procedural due process rights set forth in Article 10.

(e) If a Practitioner withdraws an initial application for medical staff appointment and/or privileges at an Affiliate Hospital(s) for professional conduct or clinical competency concerns, such application withdrawal shall automatically and equally apply to applications for Medical Staff appointment and/or Privileges at this Hospital without recourse to the procedural due process rights set forth in Article 10.

ARTICLE 10
HEARINGS & APPEALS

10.1. APPLICABILITY

10.1.1 The purpose of this Article is to provide a mechanism for resolution of matters Adverse to Medical Staff Members who have been granted Medical Staff appointment and/or Privileges at the Hospital, or Practitioner applicants who have requested Medical Staff appointment and/or Privileges at the Hospital.

10.1.2 This Article is not applicable to Advanced Practice Providers. Procedural due process rights for Advanced Practice Providers are set forth in the Advanced Practice Provider Policy.

10.2. EFFECT OF ADVERSE RECOMMENDATION OR ACTION

10.2.1 By the MEC. Unless otherwise provided in the Medical Staff Bylaws or Manuals/Policies, when a Practitioner receives Special Notice of an Adverse recommendation of the MEC the Practitioner shall be entitled to a hearing and appellate review, if applicable, in accordance with the procedures set forth in this Article.

10.2.2 By the Board. Unless otherwise provided in the Medical Staff Bylaws or Manuals/Policies, when a Practitioner receives Special Notice of an Adverse recommendation or action of the Board, and such decision is not based upon a prior Adverse recommendation of the MEC with respect to which the Practitioner was entitled to a hearing, the Practitioner shall be entitled to a hearing and appellate review, if applicable, in accordance with the procedures set forth in this Article.

10.3. RIGHT TO A HEARING

10.3.1 Adverse Recommendation or Action. Unless otherwise provided in the Medical Staff Bylaws or Manuals/Policies, the following recommendations or actions, if deemed Adverse (as such term is defined in these Bylaws), shall entitle the Practitioner affected thereby to a hearing:

(a) Denial of initial Medical Staff appointment, reappointment, and/or Privileges.

(b) Suspension, limitation, or reduction of a Practitioner's Medical Staff appointment and/or Privileges in excess of fourteen (14) days as part of a corrective action process.

(c) Imposition of a focused professional practice evaluation resulting in a limitation on previously exercised Privileges in excess of fourteen (14) days as part of a corrective action process.

(d) Termination of Medical Staff appointment and/or Privileges as part of a corrective action process.

(e) Other Adverse recommendations or actions as so designated by the MEC or the Board.

10.3.2 When Deemed Adverse. A recommendation or action listed in Section 10.3.1 shall be deemed Adverse, as such term is defined in these Medical Staff Bylaws, only when it has been:

(a) Recommended by the MEC; or,

(b) Taken by the Board under circumstances where no prior right to request a hearing existed.

10.4. ACTIONS THAT DO NOT GIVE RIGHT TO A HEARING

10.4.1 Recommendations or actions pertaining to a Practitioner's Medical Staff appointment and/or Privileges that are based on a matter which does not relate to the clinical competence or professional conduct of a Practitioner shall not give rise to hearing or appellate review rights unless otherwise specified in the Medical Staff Bylaws or Manuals/Policies.

10.4.2 The following actions are not deemed to be Adverse and shall not constitute grounds for, or entitle the Practitioner to request, a hearing:

(a) An oral or written warning or reprimand.

(b) Focused or ongoing professional practice evaluation as part of the routine peer review process.

(c) The denial, modification, limitation, suspension, or termination of temporary, emergency, disaster, telemedicine, or moonlighting Privileges.

(d) Automatic suspension or automatic termination of Medical Staff appointment and/or Privileges pursuant to the grounds set forth in these Bylaws.

(e) Any action recommended/taken by the MEC or the Board against a Practitioner where the action was recommended/taken solely for administrative or technical failings of the Practitioner (*e.g.,* determination of ineligibility for Medical Staff appointment and/or Privileges based on a failure to meet baseline qualifications; failure to provide requested information, *etc.*).

(f) Ineligibility for Medical Staff appointment, reappointment, and/or the Privileges requested because a Department/Section has been closed or the Hospital is presently a party to an exclusive contract for such services.

(g) Ineligibility for Medical Staff appointment and/or requested Privileges because of the Hospital's lack of facilities, equipment, or support services; because the Hospital has elected not to perform or does not provide the service or the procedure for which Privileges are sought; or, inconsistency with the Hospital's strategic plan.

(h) Termination of the Practitioner's employment or other contract for services unless the employment/services contract or these Bylaws provide(s) otherwise.

(i) Resignation of Medical Staff appointment and/or Privileges.

(j) Any other recommendation or action made/taken by the MEC or Board that does not relate to the clinical competence or professional conduct of a Practitioner unless the Medical Staff Bylaws or Manuals/Policies specifically state such action to be Adverse.

10.5. NOTICE OF ADVERSE RECOMMENDATION/ADVERSE ACTION

10.5.1 In all cases in which an Adverse recommendation or action has been initiated that gives rise to the right to a hearing pursuant to these Bylaws, the Chief of Staff (or Hospital President if the Adverse action was initiated by the Board) shall promptly notify the Practitioner of the Adverse recommendation or action and of the Practitioner's right to request a hearing. Such notice shall be by Special Notice.

10.5.2 The Notice of Adverse Recommendation/Adverse Action shall set forth the following:

(a) A description of the Adverse recommendation or action.

(b) The reasons for the Adverse recommendation or action including a concise statement of the basis for the recommended denial of Medical Staff appointment and/or Privileges; or, in the case of a corrective action, the Practitioner's activities or conduct (including a list of specific or representative patient medical records, where applicable) and any other information forming the basis for the Adverse recommendation or action.

(c) A statement that the Practitioner has a period of thirty (30) days after the date of receipt of the Notice of Adverse Recommendation/Adverse Action within which to request a hearing and the manner in which to do so.

(d) A summary of the Practitioner's hearing rights as hereinafter set forth.

(e) A statement that if the Practitioner fails to request a hearing, in the manner and within the time-period prescribed, such failure shall constitute a waiver of his/her right to a hearing and to an appellate review on the issue that is the subject of the Notice of Adverse Recommendation/Adverse Action.

10.6. REQUEST FOR (OR WAIVER OF) A HEARING

10.6.1 A Practitioner's request for a hearing shall be made, by Special Notice, to the Chief of Staff (or Hospital President if the Adverse action was initiated by the Board) and must be received within thirty (30) days following the Practitioner's receipt of the Notice of Adverse Recommendation/Adverse Action.

10.6.2 If the Practitioner does not request a hearing, within the time-period and in the manner described, such action shall constitute a waiver of any right to a hearing and appellate review to which he/she might otherwise have been entitled. The Adverse recommendation or action shall thereafter be presented to the Board for final decision. The Practitioner shall be informed of the Board's final decision by Special Notice.

10.7. NOTICE OF HEARING

10.7.1 Upon receipt of a timely and proper request for a hearing from the affected Practitioner, the Chief of Staff (or Hospital President if the Adverse action was initiated by the Board) shall promptly schedule and arrange for a hearing.

10.7.2 Not less than thirty (30) days prior to the hearing, the Chief of Staff (or Hospital President, as appropriate) shall give written notice to the affected Practitioner of the:

(a) Date, time, and place of the hearing.

(b) A list of witnesses, if any, expected to testify at the hearing in support of the Adverse recommendation or action on behalf of the MEC or Board, as applicable.

(c) A time frame within which the Practitioner must provide the MEC or Board, as applicable, with his/her list of witnesses.

(d) A schedule for exchange of documents upon which each party expects to rely at the hearing.

10.7.3 The *Notice of Hearing* shall be delivered to the Practitioner by Special Notice.

10.7.4 The hearing shall not be held sooner than thirty (30) days after the date of the *Notice of Hearing* unless an earlier hearing date has been specifically agreed to, in writing, by the parties. When the request is received from a Medical Staff Member who is under summary suspension, every effort shall be made to hold the hearing as soon as possible provided the Medical Staff Member agrees to waive the time requirements set forth in this section.

10.7.5 Each party remains under a continuing obligation to provide to the other party the names of any witnesses or any documents identified after the initial exchange which such party intends to introduce at the hearing. The introduction of any documents

not provided prior to the hearing, or the admissibility of testimony to be presented by a witness not so listed, shall be at the discretion of the presiding officer.

10.8. HEARING OFFICER OR HEARING PANEL

10.8.1 The hearing shall be conducted by either a hearing officer or a hearing panel as determined by whichever body (*i.e.,* the MEC or the Board) made the Adverse recommendation or took the Adverse action that is the basis for the hearing.

(a) Appointment of a Hearing Officer. A hearing officer may be a Practitioner, an attorney, or other individual qualified to conduct the hearing as determined by the MEC or Board, as applicable. The hearing officer is not required to be a Medical Staff Member. A hearing officer shall also act as the presiding officer pursuant to Section 10.9.

(b) Appointment of a Hearing Panel. A hearing panel shall consist of not less than three (3) persons chosen by the MEC or Board, as applicable. The hearing panel members may either be Practitioners or individuals from outside of the Hospital, or a combination thereof, as determined by the MEC or Board, as appropriate. At least two (2) members of the hearing panel should be Practitioners.

(1) The chair of the hearing panel shall preside over the proceeding.

(2) The appointing body shall designate one (1) member of the hearing panel as the panel chair. If the MEC or Board, as applicable, elects not to designate the panel's chair, one (1) of the panel members shall be appointed as chair pursuant to a majority vote of the panel members. The presiding officer, if a member of the hearing panel, may participate in the panel's deliberations and shall be entitled to vote.

(3) In the alternative, the MEC or Board, as applicable, may appoint an active or retired attorney in addition to the hearing panel to act as presiding officer; provided, however, that such individual shall not be entitled to vote on the hearing panel's recommendation.

10.8.2 Disqualification. Any person shall be disqualified from serving as a hearing officer, on a hearing panel, or as a presiding officer if the individual: directly participated in initiating the Adverse recommendation or action or in investigating the underlying matter at issue; has taken an active part in the matter contested; is professionally associated with or related to the Practitioner requesting the hearing; or, is a direct economic competitor or otherwise has a Conflict of Interest with the involved Practitioner. In the event that an attorney serves as the hearing officer, on the hearing panel, or as a presiding officer, he/she must not represent clients in direct economic competition with the Practitioner who is the subject of the hearing.

10.8.3 Objections. A Practitioner shall have ten (10) days following notice of the appointment of a hearing officer or hearing panel to advise the Chief of Staff (or Hospital President if the Adverse action was initiated by the Board), in writing, of any objections that the Practitioner has with respect to any such appointment(s). The Chief of Staff (or Hospital President, as appropriate) shall advise the appointing body of the objections. The appointing body, in its sole discretion, shall decide whether a substitution should be made. Failure of a Practitioner to make such objection shall be deemed a waiver of any objection to the appointment(s).

10.9. PRESIDING OFFICER

10.9.1 The hearing officer, the hearing panel chair, or other designated individual, as applicable, shall serve as the presiding officer.

10.9.2 The presiding officer shall act to maintain decorum and to assure that all participants in the hearing process have a reasonable opportunity to present relevant oral and documentary evidence. The presiding officer shall make all rulings on matters of law, procedure, and the admissibility of evidence.

10.9.3 If the presiding officer determines that either side is not proceeding in an efficient and expeditious manner, the presiding officer may take such action as is warranted by the circumstances.

10.10. HEARING PROCEDURE

10.10.1 Failure to Appear or Proceed. The personal presence of the Practitioner who requested the hearing is required. A Practitioner who fails, without good cause, to appear and proceed at the hearing shall be deemed to have waived his or her right to such hearing and to any appellate review to which he/she might otherwise have been entitled.

10.10.2 Postponements and Extensions. Prior to the beginning of the hearing, the Chief of Staff (or Hospital President, as appropriate), in discussion with the hearing officer or hearing panel, shall determine whether a request for postponement of a hearing should be granted. The presumption shall be that the hearing will go forward on its scheduled date in the absence of a showing of good cause. Once the hearing has begun, the hearing officer or hearing panel shall be responsible for determining whether any continuances should be granted based upon the same standard.

10.10.3 Representation

(a) The Practitioner may be represented by legal counsel or another person of the Practitioner's choice provided that such other person agrees to maintain the confidentiality of the peer review proceedings.

(b) The Chief of Staff (on behalf of the MEC) or the Hospital President (on behalf of the Board) may appoint an attorney or one of its members to represent the MEC or Board at the hearing, to present the facts in support of its Adverse recommendation or action, and to examine witnesses. If an attorney is chosen to represent the MEC or Board, then either of those bodies, as applicable, may also appoint one of its members to present the facts in support of its Adverse recommendation or action.

(c) If either party will be accompanied by legal counsel, notice must be given to the other party at such time as counsel is obtained.

10.10.4 No Right to Discovery. There is no right to discovery in connection with the hearing; provided, however, that the Practitioner requesting the hearing shall be entitled to documentation relied upon by the MEC or the Board in making the Adverse recommendation or taking the Adverse action subject to written attestation by the Practitioner and his/her legal counsel stating that all documents shall be maintained as confidential and shall not be disclosed or used for any purpose outside of the hearing.

10.10.5 Prehearing Procedure. The affected Practitioner and the body whose Adverse recommendation or action prompted the hearing should notify the presiding officer of any pending or anticipated procedural disputes as far in advance of the scheduled hearing as necessary to permit advance decisions concerning such matters. Objection to any pre-hearing decisions or procedures may be put on the record at the time of the hearing.

10.10.6 Record of the Hearing. A record of the hearing shall be kept of sufficient accuracy that an informed and valid judgment can be made by any group that may later be called upon to review the record and render a recommendation or decision in the matter. The hearing officer or panel shall arrange for a court reporter to transcribe the hearing. Upon request, the Practitioner shall be entitled to obtain a copy of the record at his/her own expense.

10.10.7 Rights of the Parties. At the hearing, the parties shall have the following hearing rights:

(a) To be represented by an attorney or other person of the party's choice.

(b) To be provided with a list of witnesses and copies of documents that will be relied upon by the other party at the hearing subject to Section 10.7.

(c) To have a record made of the proceedings, copies of which may be obtained by the Practitioner upon payment of any reasonable charges associated with the preparation thereof.

(d) To call, examine, and cross-examine witnesses.

(e) To introduce relevant exhibits and documents. To present and/or rebut any evidence determined relevant by the hearing officer or hearing panel regardless of the admissibility of the evidence in a court of law.

(f) To impeach (challenge the credibility of) witnesses.

(g) To submit a written statement at the close of the hearing.

(h) Upon completion of the hearing, to receive a copy of the written recommendation of the hearing officer or hearing panel (including a statement of the basis for the hearing officer's or hearing panel's recommendation(s)) and to receive a copy of the written decision of the Board (including a statement of the basis for the Board's decision).

10.10.8 Practitioner Testimony. If the Practitioner who requested the hearing does not testify on his/her own behalf, he/she may be called to testify and examined as if under cross-examination.

10.10.9 Hospital Employees. Neither the Practitioner, nor his/her attorney, nor any other person on behalf of the Practitioner shall contact Hospital employees during an employee's working hours at the Hospital. The Practitioner or his/her attorney or other agent may contact the Hospital President or legal counsel to the MEC or Board, as applicable (if representation has been obtained), to request assistance in talking with Hospital employees. At his/her request, a Hospital employee may be accompanied by legal counsel (who may be the counsel who represents the MEC or Board, as applicable) when meeting with the Practitioner or his/her attorney or other agent. Although Hospital employees will be encouraged to participate in the hearing process, all such participation shall be voluntary and the Hospital shall not have the authority to demand participation unless such participation is part of the employee's job description.

10.10.10 Observers. The hearing shall be restricted to those individuals involved in the proceeding. Appropriate administrative personnel may be present as requested by the Hospital President and the Chief of Staff and approved by the hearing officer or panel. All aspects of the proceedings shall be considered privileged, confidential, and protected by Ohio law and shall not be open to the public.

10.10.11 Burden of Proof

(a) At the hearing, the MEC or the Board, as applicable, and the Practitioner may make opening statements.

(b) Following the opening statements, the body whose Adverse recommendation or action gave rise to the hearing shall have the initial obligation to present evidence, establishing the basis for its Adverse recommendation or action.

(c) The Practitioner shall have the burden of proving, by clear and convincing evidence, that the Adverse recommendation or action lacks any factual basis or that such basis, or the conclusions drawn therefrom, are arbitrary, capricious, or not supported by substantial credible evidence.

(d) The MEC or Board, as applicable, shall also have the right to rebuttal following the presentation of the Practitioner's case.

(e) The parties may make closing statements following the introduction of all of the evidence and submit post-hearing written statements.

10.10.12 Evidentiary Matters

(a) Judicial rules of evidence and procedure relating to the examination of witnesses and presentation of evidence need not be strictly enforced, except that oral evidence shall be taken only on oath or affirmation administered by any person designated by the presiding officer and entitled to notarize documents in the State of Ohio. The hearing officer or hearing panel may consider any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs regardless of whether such evidence would be admissible in a court of law. The parties may, at the discretion of the presiding officer, submit memoranda concerning any issue of procedure or fact and such memoranda shall become a part of the hearing record.

(b) In reaching a decision, the hearing officer or panel may take official note at any time for evidentiary purposes of any generally accepted technical or scientific principles related to the matter at hand and of any facts that may be judicially noticed by Ohio courts. The parties to the hearing shall be informed of the principles or facts to be noticed and the same shall be noted in the hearing record. Either party shall be given the opportunity to request that a principle or fact be officially noticed or to refute any officially noticed principle or fact by evidence or by written or oral presentation of authority in such manner as determined by the hearing officer or panel.

(c) The hearing officer or panel may ask questions of the parties and their witnesses.

10.10.13 Recesses and Adjournment

(a) The hearing officer or panel may recess the hearing and reconvene it without additional notice for the convenience of the participants, to obtain new or additional evidence, or if consultation is required for resolution of the matter.

(b) When presentation of oral and written evidence is complete, the hearing shall be closed.

(c) The hearing shall be adjourned upon receipt of the transcript of the proceedings and any closing written statements, whichever occurs later. The hearing officer or panel shall thereafter deliberate outside the presence of the parties at such time and in such location as is convenient.

10.10.14 Report & Recommendation of Hearing Officer or Hearing Panel

(a) Within thirty (30) days after adjournment of the hearing, the hearing officer or panel shall report, in writing, its findings and recommendation (including a statement of the basis for such recommendation with specific references to the hearing record) and shall forward the report, along with the hearing record and documentation introduced at the hearing and considered by the hearing officer or panel, to the body whose Adverse recommendation or action gave rise to the hearing.

(b) The hearing recommendation shall be based exclusively upon the written and oral evidence introduced and presented at the hearing and any memoranda submitted by the parties.

10.10.15 Action Upon Receipt of Hearing Officer or Hearing Panel Report & Recommendation. Within fourteen (14) days after receipt of the report and recommendation from the hearing officer or panel, the body whose Adverse recommendation or action gave rise to the hearing shall consider the same and affirm, modify, or reverse its original Adverse recommendation or action in the matter.

(a) Favorable Recommendation/Action

(1) When the MEC's recommendation is favorable to the Practitioner, the Board may adopt or reject any portion of the MEC's recommendation that was favorable to the Practitioner or refer the matter back to the MEC for additional consideration. Any such referral shall state the reason(s) for the requested reconsideration, set a time limit within which a subsequent recommendation must be made to the Board, 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 action.

(2) A favorable determination by the Board (whether as the initiating body or in affirmance of a favorable recommendation by the MEC) shall be effective as the Board's final decision and the matter shall be considered closed.

(b) Adverse Recommendation/Action. If the recommendation of the MEC or action of the Board continues to be Adverse to the affected Practitioner after exhaustion of his/her hearing rights, the Practitioner shall be entitled, upon

timely and proper request, to an appellate review before a final decision is rendered on the matter by the Board.

10.10.16 Notice of Result

(a) Such recommendation or action of the MEC/Board shall be transmitted, together with the hearing record, the report of the hearing officer or panel, and all other documentation introduced at the hearing and considered by the hearing officer or panel, to the Hospital President.

(b) The Hospital President shall promptly send a copy of the hearing officer's or panel's report, together with a copy of the subsequent determination of the body whose Adverse recommendation or action initially gave rise to the hearing, to the affected Practitioner by Special Notice.

(c) In the event of an Adverse result, the notice shall inform the Practitioner of his/her right to request an appellate review by the Board before a final decision regarding the matter is rendered.

10.11. APPEAL TO HOSPITAL BOARD FOLLOWING HEARING

10.11.1 Time for Appeal

(a) The Practitioner shall have fourteen (14) days after receiving notice of his/her right to request an appellate review to submit a written request for such review. Such request shall be delivered, by Special Notice, to the Hospital President.

(b) If the Practitioner wishes an attorney to represent him/her at any appellate review appearance permitted, his/her request for appellate review shall so state.

(c) The request shall also state whether the Practitioner wishes to present oral arguments (him/herself or through the Practitioner's attorney) to the appellate review body.

10.11.2 Waiver of Right to Appeal. If the Practitioner does not request an appeal, within the time and in the manner described in Section 10.11.1, such failure shall constitute a waiver of his/her right to an appeal. The Adverse recommendation or action shall thereafter be presented to the Board for final decision. The Practitioner shall be informed of the Board's final decision by Special Notice.

10.11.3 Time, Place, and Notice. If appellate review is timely and properly requested, the Hospital President shall deliver such request to the Board. As soon as practicable, the Board chair shall schedule and arrange for the appellate review.

(a) At least ten (10) days prior to the date of the appellate review the Hospital President shall advise the Practitioner, by Special Notice, of the date, time, and place of the review and whether oral arguments will be permitted.

(b) The date of the appellate review shall not be less than ten (10) days, nor more than thirty (30) days, from the date of the Notice of Appellate Review, except that when the Practitioner requesting the review is under a suspension which is then in effect such review shall be scheduled as soon as arrangements for it may reasonably be made provided that the Practitioner agrees to waive the time requirements set forth in this section. The appellate review body may extend the time for the appellate review for good cause if such request is made as soon as is reasonably practicable.

10.11.4 Appellate Review Body. The Board chair shall decide whether to have the entire Board hear the appeal or to appoint an appellate review panel comprised of not less than three (3) Board members ("Appeal Panel"). To the extent possible, the Appeal Panel shall include a Practitioner who is a Board member.

10.11.5 Presiding Officer. The Board chair shall determine whether the presiding officer shall be a member of the full Board, the Appeal Panel, or an attorney. The presiding officer shall preside over the appellate review and have the same role as provided in Section 10.9.

10.11.6 Appeal Proceeding

(a) The proceedings by the Board or Appeal Panel shall be in the nature of an appellate review based upon the record of the hearing before the hearing officer or hearing panel, the hearing officer's or hearing panel's report, and all subsequent results and actions thereon for the purpose of determining whether the Practitioner was denied a fair hearing and/or whether the Adverse recommendation or action against the affected Practitioner was justified, as supported by substantial, credible evidence presented at the hearing, and not arbitrary or capricious.

(b) The appellate review body shall also consider any written statements submitted pursuant to Section 10.11.8.

(c) The affected Practitioner shall have access to the report and record of the hearing officer or hearing panel and the MEC and/or the Board, as applicable, and all material, favorable or unfavorable, that was introduced at the hearing and considered in making the Adverse recommendation or taking the Adverse action against the Practitioner.

10.11.7 Consideration of New/Additional Evidence. If a party wishes to introduce new/additional evidence not raised or presented during the original hearing and not otherwise reflected in the record, the party must make such request in writing at the time he/she submits a request for appellate review pursuant to Section 10.11.1.

(a) The party may introduce such evidence at the appellate review only if expressly permitted by the Board or Appeal Panel, in its sole discretion, and only upon a clear showing by the party requesting consideration of the evidence that it is new, relevant evidence not previously available at the time of the hearing; or, that a request to admit relevant evidence was previously erroneously denied.

(b) In the exceptional circumstance where the Board or Appeal Panel determines to hear such evidence, the Board or Appeal Panel shall further have the ability to recess appellate review and remand the matter back to the hearing officer or hearing panel.

(c) In such event, the hearing shall be reopened as to this evidence only and the evidence shall be subject to submission and cross-examination and/or counter-evidence.

(d) The hearing officer or hearing panel shall prepare a supplemental report and submit it to the body whose Adverse recommendation or action initially gave rise to the hearing. The initiating body will then notify the Board or Appeal Panel, in writing, through the Hospital President as to whether the initiating body will or will not be amending its Adverse recommendation or action and, as applicable, the nature of the amendment or reason for non-amendment.

(e) The Hospital President shall then provide a copy of the hearing officer's or hearing panel's supplemental report and the initiating body's recommendation/action to the Practitioner and the appellate review process shall recommence or conclude, as applicable.

10.11.8 Written Statements. The Board or Appeal Panel shall set a date by which written statements must be submitted to it (through the Hospital President) and to the opposing party. The Practitioner's statement should describe the facts, conclusions, and procedural matters with which he/she disagrees including the reasons for such disagreement. The statement of the body whose Adverse recommendation or action occasioned the review should discuss the basis upon which it believes its recommendation/action should be upheld.

10.11.9 Oral Arguments. The decision to permit oral arguments shall be in the sole discretion of the Board or Appeal Panel. The Board or Appeal Panel shall further decide what time limits, if any, should be placed upon the arguments and whether the arguments will be presented separately or with representatives of both parties in the room. Parties and their representatives appearing before the Appeal Panel or Board must be willing to answer questions posed to them by the Board or Appeal Panel.

10.11.10 Presence of Members and Vote. A majority of the Board or Appeal Panel shall be present at all times during the review and deliberations. If a Board member

or an Appeal Panel member is absent from any part of the review or deliberations, the presiding officer, in his/her discretion, may rule that such member be excluded from further participation in the review or deliberations or in the recommendation of the Board or Appeal Panel.

10.11.11 Recesses and Adjournments. The Board or Appeal Panel may recess the appellate review proceeding and reconvene the same without additional notice if it deems such recess necessary for the convenience of the participants, to obtain new or additional evidence, or if consultation is required for resolution of the matter. Upon conclusion of oral statements, if allowed, the appellate review shall be closed. The Board or Appeal Panel shall then deliberate outside the presence of the parties at such time and in such location as is convenient to the Board or Appeal Panel. The appellate review shall be adjourned at the conclusion of the Board or Appeal Panel's deliberations.

10.11.12 Recommendation by Appeal Panel. If the appellate review is conducted by an Appeal Panel, within fifteen (15) days after adjournment of the appellate review, the Appeal Panel shall issue a written report recommending that the Board: affirm, modify, or reverse its prior Adverse action; accept or reject the Adverse recommendation of the MEC; or refer the matter back to the MEC for further review and recommendation. Such referral back to the MEC may include a request that the MEC arrange for a further hearing to resolve disputed issues and a specified time-period in which to do so and report back to the Board.

10.11.13 Final Decision of the Board

(a) Within thirty (30) days after receipt of the Appeal Panel's recommendation, or adjournment of the appellate review if heard by the Board as a whole, the Board shall consider the recommendation of the Appeal Panel, if one was utilized, and make a determination to: affirm, modify, or reverse the Board's prior Adverse action; accept or reject the Adverse recommendation of the MEC; or refer the matter back to the MEC for further review and recommendation. Such referral back to the MEC may include a request that the MEC arrange for a further hearing to resolve disputed issues and a specified time-period in which to do so and report back to the Board.

(1) If the Board's decision is in accordance with the MEC's last recommendation or the Board's last action in the matter, it shall be immediately effective and final and shall not be subject to further hearing or appellate review.

(2) If the Board's decision is contrary to the MEC's last recommendation or the Board's last action, the Board shall refer the matter to the Joint Conference Committee prior to issuing notice of its final decision. The Joint Conference Committee shall make its written recommendation to the Board within the time-period

specified by the Board. The Board shall then make its final decision. The Board's final decision shall be immediately effective and the matter shall not be subject to any further referral or review.

(b) The Hospital President will promptly send written notice of the Board's final decision to the affected Practitioner, by Special Notice, and to the Chief of Staff. The notice to the Practitioner shall include a statement of the basis for the Board's final decision.

10.12. GENERAL PROVISIONS APPLICABLE TO A HEARING & APPEAL

10.12.1 Right to Hearing. No Practitioner shall be entitled to more than one (1) hearing and one (1) appeal on any matter that may be the subject of a hearing/appeal. Adverse recommendations or actions on more than one (1) matter may be consolidated and considered together or separately as the Board shall designate in its sole discretion.

10.12.2 Waiver. If at any time after receipt of notice of an Adverse recommendation or action the affected Practitioner fails to satisfy a request, make a required appearance, or otherwise fails to comply with the Medical Staff governing documents, he/she shall be deemed to have voluntarily waived all rights to which he/she might otherwise have been entitled with respect to the matter involved.

10.12.3 Exhaustion of Remedies. A Practitioner must exhaust the remedies afforded by the Medical Staff governing documents before resorting to any form of legal action.

10.12.4 Release. By requesting a hearing and/or appellate review, a Practitioner agrees to be bound by the applicable provisions set forth in these Medical Staff Bylaws relating to confidentiality, immunity, and release of liability.

10.12.5 Representation by Counsel. At such time as the Practitioner, MEC, or Board is represented by legal counsel, then all notices required to be sent herein may be served upon legal counsel and the requirement that such notices be sent by Special Notice is hereby waived; rather, such notices may thereafter be sent by regular first-class U.S. mail, electronically, by facsimile, or in such other form as is mutually agreed to by the parties.

10.12.6 Reporting. The Hospital President or Chief Medical Officer shall, in consultation with legal counsel, report any final action taken by the Board pursuant to the Medical Staff governing documents to the appropriate authorities as required by law and in accordance with applicable Hospital procedures regarding the same.

ARTICLE 11
MEDICAL HISTORY & PHYSICAL EXAMINATION

11.1. HISTORY AND PHYSICAL

11.1.1 General Requirement. A medical history and physical examination (H&P) must be completed and documented for each patient, as applicable, no more than 30 days before or within 24 hours after admission or registration but prior to surgery or a procedure requiring anesthesia services (expect in emergency situations).

11.1.2 H&P Update. For an H&P that was completed within 30 days before admission or registration, an updated examination of the patient, including any changes in the patient's condition, must be completed and documented within 24 hours after admission or registration but prior to surgery or a procedure requiring anesthesia services (except in emergency situations).

11.1.3 Authorization to Complete/Document

(a) The following qualified licensed individuals may complete and document H&Ps (and an update thereto, when required) subject to the conditions that follow:

(i) Physicians

(ii) Oral Surgeons

(iii) Dentists (who are not Oral Surgeons)/(dental portion only)

(iv) Podiatrists

(v) Psychologists (psychological portion only)

(vi) Certified Nurse Midwives; Clinical Nurse Specialists; Certified Nurse Practitioners

(vii) Physician Assistants

(b) Practitioners and APPs authorized to complete and document H&Ps (and an update thereto, when required) must be licensed to practice their profession in Ohio and providing services within their authorized scope of practice pursuant to applicable state laws and rules/regulations.

(c) With the limited exception set forth in Section 11.1.3 (d), Practitioners and APPs authorized to complete and document H&Ps (and an update thereto, when required) must be granted Privileges by the Hospital to do so.

(d) The Hospital may accept H&Ps that are completed and documented within 30 days before the patient's Hospital admission/registration by an authorized individual set forth in Section 11.1.3 (a).

(1) Authorized individuals who complete and document H&Ps in this circumstance are not required to have Privileges at the Hospital but must be licensed to practice their profession in Ohio and providing services within their authorized scope of practice pursuant to applicable state laws and rules/regulations. Example: The H&P is completed in advance by the patient's primary care Physician who is licensed to practice medicine in Ohio but not granted Privileges at the Hospital.

(2) In such event, an update must thereafter be completed and documented in accordance with the requirements set forth in Section 11.1.2 by an authorized individual set forth in Section 11.1.3 (a) who is granted Privileges by the Hospital to complete and document H&Ps (and an update thereto, when required).

11.1.4 Inclusion in Medical Record. The H&P (and an update thereto, when required) shall be available in the patient's medical record within twenty-four (24) hours after registration or inpatient admission, but prior to surgery or a procedure requiring anesthesia services (except in emergency situations).

11.1.5 Additional Details. Additional requirements and details regarding completion and documentation of the H&P (and an update thereto, when required) are set forth in the Medical Staff Rules and Regulations and/or in applicable System/Hospital policies.

ARTICLE 12
ADOPTION AND AMENDMENT OF MEDICAL STAFF BYLAWS, MANUALS/POLICIES, AND RULES & REGULATIONS

12.1. MEDICAL STAFF RESPONSIBILITY

12.1.1 The Medical Staff shall have the responsibility to formulate, adopt, and amend these Medical Staff Bylaws and to recommend any such changes thereto to the Board which changes shall be effective only when approved by the Board. Such responsibility shall be exercised in good faith and in a reasonable, responsible, and timely manner.

12.1.2 Neither the Board nor the Medical Staff may unilaterally adopt or amend the Medical Staff Bylaws. Rather, the provisions set forth in this Article shall be the sole means for creating and adopting or amending the Medical Staff Bylaws.

12.1.3 The Medical Staff Bylaws, Manuals/Policies, and the Rules and Regulations shall be reviewed and updated as necessary to assure congruence with Medical Staff practice and changes in applicable laws, rules, regulations, and accreditation standards, but at least once every three (3) years.

12.2. ADOPTION & AMENDMENT OF MEDICAL STAFF BYLAWS

12.2.1 Proposal of Amendments. Amendments to the Medical Staff Bylaws may be proposed by the Hospital President, the CMO, a Medical Staff officer, Department Chair/Section Chair, the MEC or chair of another standing Medical Staff committee, or by twenty-five percent (25%) of the Medical Staff Members eligible to vote.

12.2.2 Review/recommendation by the KH Medical Staff Bylaws Alignment Committee

(a) The KH Medical Staff Bylaws Alignment Committee shall review and make a recommendation regarding an amendment proposed to the Medical Staff Bylaws that is applicable to the Hospital and Affiliate Hospitals.

(b) An amendment proposed to the Medical Staff Bylaws specific to the Hospital but not the Affiliate Hospitals (such as a change to the Hospital's MEC composition) may be (but is not required to be) reviewed/recommended by the KH Medical Staff Bylaws Alignment Committee.

(c) An amendment proposed to the Medical Staff Bylaws specific to the Hospital shall be reviewed/recommended by the Medical Staff Bylaws Committee, if any, specific to the Hospital.

12.2.3 Review/recommendation by the MEC

(a) Following receipt and consideration of a recommendation from, as applicable, the KH Medical Staff Bylaws Alignment Committee and/or the Hospital's Medical Staff Bylaws Committee (if any), the MEC shall present the Medical Staff Bylaws, or proposed amendment(s) thereto, along with the MEC's recommendation, to the Medical Staff Members eligible to vote in such manner as determined appropriate by the MEC.

(b) The Medical Staff Bylaws, or amendments thereto, shall be made available for review by the Medical Staff Members eligible to vote at least ten (10) days prior to a Medical Staff vote regarding adoption or amendment.

12.2.4 Action by the Medical Staff. Adoption or amendment of the Medical Staff Bylaws by the Medical Staff shall occur in one of the following ways at the discretion of the MEC:

(a) By a two-thirds (2/3rd) affirmative vote of those Medical Staff Members eligible to vote who are present at a Medical Staff meeting at which a quorum is present.

OR

(b) By ballot without a Medical Staff meeting. In such event, ballots shall be distributed to each Medical Staff Member eligible to vote. Ballots may be distributed electronically or in such other manner as determined appropriate by the MEC. Completed ballots must be returned within the time-period specified and according to the instructions that accompany the ballot. Ballots received after the stipulated date shall not be counted. Adoption or amendment of the Medical Staff Bylaws in this manner shall require a two-thirds (2/3rd) affirmative vote of the total ballots returned by the stipulated date.

12.2.5 Action by the Board. Adoption or amendment of the Medical Staff Bylaws requires approval of the Board.

(a) If the Board has determined not to accept action regarding the Medical Staff Bylaws submitted to it by the Medical Staff, the Joint Conference Committee shall be convened. Such conference shall be for the purpose of communicating the Board's rationale for its contemplated action and permitting the Medical Staff officers to discuss the rationale for the Medical Staff's position.

(b) Following a recommendation from the Joint Conference Committee, the Board may take final action.

12.3. TECHNICAL AMENDMENT OF THE MEDICAL STAFF BYLAWS

12.3.1 The MEC may make corrections to the Medical Staff Bylaws that are, in the judgment of the MEC: minor; non-substantive; technical changes/modifications;

clarifications; reorganization; renumbering; or amendments due to punctuation, spelling, or grammar.

12.3.2 Technical amendment of the Medical Staff Bylaws requires an affirmative vote of two-thirds (2/3rds) of the MEC members in the manner set forth in Section 12.4.3 (a) or (b) and shall become effective immediately. A recommendation from the KH Medical Staff Bylaws Alignment Committee or from the Medical Staff Bylaws Committee, if any, specific to the Hospital is not necessary. No prior notice to the Medical Staff or Board of such change is required.

12.3.3 Technical amendment of the Medical Staff Bylaws will be communicated to the Medical Staff and Board and will be deemed approved if not objected to by the Medical Staff and/or Board within thirty (30) days after adoption by the MEC.

12.4. ADOPTION AND AMENDMENT OF MEDICAL STAFF MANUALS/POLICIES AND RULES & REGULATIONS

12.4.1 Delegation to the MEC. The Medical Staff has delegated to the MEC, subject to Board approval, the ability to adopt and amend such Medical Staff Manuals/Policies and Rules & Regulations as necessary to detail the processes/procedures and implement the general principles set forth in these Medical Staff Bylaws. Adoption or amendment of a Medical Staff Manual/Policy or the Rules & Regulations will not require the approval of the Medical Staff Members eligible to vote.

12.4.2 Review/recommendation by the KH Medical Staff Bylaws Alignment Committee

(a) The KH Medical Staff Bylaws Alignment Committee may review and make a recommendation to the MEC regarding an amendment proposed to a Medical Staff Manual/Policy or the Rules & Regulations that is applicable to the Hospital and Affiliate Hospitals.

(b) An amendment proposed to a Medical Staff Manual/Policy or the Rules & Regulations specific to the Hospital but not the Affiliate Hospitals (such as a change to the composition of a Hospital's standing Medical Staff committees) may be (but is not required to be) reviewed/recommended by the KH Medical Staff Bylaws Alignment Committee.

(c) An amendment proposed to a Medical Staff Manual/Policy or the Rules & Regulations specific to the Hospital shall be reviewed/recommended by the Medical Staff Bylaws Committee, if any, specific to the Hospital.

12.4.3 Action by the MEC. Following receipt and consideration of a recommendation from, as applicable, the KH Medical Staff Bylaws Alignment Committee and/or the Hospital's Medical Staff Bylaws Committee (if any), the MEC shall act. Adoption or amendment of a Medical Staff Manual/Policy or the Rules & Regulations by the MEC shall occur in one of the following ways at the discretion of the MEC:

(a) By a two-thirds (2/3rd) affirmative vote of those MEC members eligible to vote who are present at a MEC meeting at which a quorum is present.

OR

(b) By ballot without a MEC meeting. In such event, ballots shall be distributed to each MEC member eligible to vote. Ballots may be distributed electronically or in such other manner as determined appropriate by the MEC. Completed ballots must be returned within the time-period specified and according to the instructions that accompany the ballot. Ballots received after the stipulated date shall not be counted. Adoption or amendment of a Medical Staff Manual/Policy or the Rules & Regulations in this manner shall require a two-thirds (2/3rd) affirmative vote of the total ballots returned by the stipulated date.

12.4.4 Action by the Board. Adoption or amendment of a Medical Staff Manual/Policy or the Rules & Regulations requires approval of the Board.

(a) If the Board has determined not to accept action regarding a Medical Staff Manual/Policy or the Rules & Regulations submitted to it by the MEC, the Joint Conference Committee shall be convened. Such conference shall be for the purpose of communicating the Board's rationale for its contemplated action and permitting the Medical Staff officers to discuss the rationale for the MEC's position.

(b) Following a recommendation from the Joint Conference Committee, the Board may take final action

12.4.5 Communication to the Medical Staff

(a) When the MEC adopts or amends a Medical Staff Manual/Policy or the Rules & Regulations, the MEC shall make such document(s) available and communicate the change(s) to the Medical Staff following Board approval.

(b) Any Medical Staff Appointee, in Good Standing, eligible to vote may raise a reasonable challenge made in good faith to any provision(s) in a Medical Staff Manual/Policy or the Rules & Regulations established by the MEC and approved by the Board. In order to raise such challenge, the Appointee must submit to the MEC a petition signed by not less than ten percent (10%) of the Appointees, in Good Standing, eligible to vote. Upon receipt of the petition, the MEC shall either (a) provide the petitioner(s) with information clarifying the intent of such provision(s); and/or (b) schedule a meeting with the petitioner(s) to discuss the issue. In the event that the issue cannot be resolved to the satisfaction of the petitioner(s), the matter shall be brought before the Medical Staff for vote and forwarded to the Board for final action.

12.5. BOARD-INITIATED ACTION

12.5.1 In the event the Medical Staff or the MEC, as applicable, fails to exercise its responsibility in good faith and in a reasonable and timely manner, and after written notice from the Board to such effect including a reasonable time for response, the Board may take action pursuant to these Bylaws.

12.5.2 Should the Medical Staff or MEC fail to respond under such circumstances or should the Board disagree with any response(s) or recommendation(s) from the Medical Staff or MEC for, as applicable, adoption or amendment of the Medical Staff Bylaws, Manuals/Policies, or Rules & Regulations, the Joint Conference Committee shall be convened. Such conference shall be for the purpose of communicating the Board's rationale for its contemplated action and permitting the Medical Staff officers to discuss the rationale for the Medical Staff's or the MEC's position.

12.5.3 Following a recommendation from the Joint Conference Committee, the Board may take final action.

12.6. DOCUMENT CONFLICTS

12.6.1 Effort shall be made to assure that the Medical Staff Bylaws, Manuals/Policies, and Rules & Regulations, the Hospital's governing documents, and applicable System/Hospital policies are compatible with each other and compliant with applicable laws, rules/regulations, and accreditation standards.

12.6.2 In the event of a conflict between the System/Hospital governing documents or a System/Hospital policy and the Medical Staff Bylaws, the System/Hospital governing documents or policy, as applicable, shall control. Such conflict shall be referred to the Joint Conference Committee for consideration and recommendation to the Board as to follow up action needed, if any.

12.6.3 In the event of a conflict between the Medical Staff Bylaws and a Medical Staff Manual/Policy or the Rules & Regulations, the Bylaws shall control. Such conflict shall then be referred to the MEC for consideration and recommendation as to follow up action needed, if any.

12.7. AVAILABILITY OF MEDICAL STAFF GOVERNING DOCUMENTS

12.7.1 Appointees of the Medical Staff and other Practitioners and APPs who have Privileges shall be provided access to the Medical Staff Bylaws, Manuals/Policies, and the Rules & Regulations, as such Medical Staff governing documents may be amended from time to time.

ARTICLE 13
CONFIDENTIALITY, IMMUNITY, AND RELEASE OF LIABILITY

13.1. SPECIAL DEFINITIONS

13.1.1 For purposes of this Article, the following definitions shall apply:

(a) INFORMATION means documentation of proceedings, minutes, interviews, records, reports, forms, memoranda, statements, investigations, examinations, hearings, meetings, recommendations, findings, evaluations, opinions, conclusions, actions, data, and other disclosures or communications, whether in written or oral form, relating to any of the subject matter specified in §13.5 of this Article.

(b) REPRESENTATIVE means the Board, Hospital, Medical Staff, its committees and agents (*e.g.,* Board members, Practitioners, APPs, Hospital employees, committee members, *etc.*) authorized to perform specific Information gathering, analysis, use or disseminating functions.

(c) THIRD PARTIES means any individual or organization providing information to any Representative.

13.2. AUTHORIZATIONS & RELEASES

13.2.1 Each Practitioner shall, upon request of the Hospital, execute general and specific releases and authorizations in accordance with the tenor and import of this Article, subject to such requirements as may be applicable under state and federal law. Execution of such releases and authorizations is not a prerequisite to the effectiveness of this Article. Such releases and authorizations will operate in addition to the provisions of this Article.

13.2.2 By submitting an application for Medical Staff appointment/reappointment and/or grant/regrant of Privileges and at all times that a Practitioner holds Medical Staff appointment and/or Privileges at the Hospital, a Practitioner:

(a) Authorizes Representatives and Third Parties, as applicable, to solicit, provide, and act upon Information bearing on his or her qualifications for Medical Staff appointment and/or Privileges.

(b) Agrees to be bound by the provisions of this Article and to waive any and all legal claims against Representatives and Third Parties who act in accordance with the provisions of this Article.

(c) Acknowledges that the provisions of this Article are express conditions to his/her application for and, as applicable, acceptance and continuation of Medical Staff appointment and/or Privileges at the Hospital.

13.3. CONFIDENTIALITY OF INFORMATION

13.3.1 Information with respect to any Practitioner submitted, collected, or prepared by a Representative or any other health care facility or organization or medical staff for the purpose of: evaluating qualifications (including, but not limited to, current clinical competence) for medical staff appointment and/or clinical privileges; reviewing, evaluating, monitoring, or improving the quality, appropriateness, and efficiency of patient care; reducing morbidity and mortality; contributing to teaching or clinical research; determining that health care services are professionally indicated and performed in accordance with the applicable standards of care; or establishing and enforcing guidelines to help keep health care costs within reasonable bounds shall, to the fullest extent permitted by law, be confidential.

13.3.2 Information shall not be disseminated to anyone other than a Representative or other health care facility or organization of health professionals or medical staff engaged in an official, authorized activity for which the Information is needed or be used in any way except as provided herein or as otherwise required by law. Such confidentiality shall also extend to Information of like kind that may be provided by/to Third Parties. This Information shall not become part of any particular patient's record.

13.3.3 It is expressly acknowledged by each Practitioner that violation of the confidentiality provisions provided herein is grounds for corrective action pursuant to these Medical Staff Bylaws.

13.4. IMMUNITY FROM LIABILITY

13.4.1 For Action Taken. 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, a Representative or Third Party, as applicable, shall not be liable to a Practitioner for damages or other relief for any decision, opinion, action, statement, or recommendation made provided that such Representative or Third Party acts within the scope of his/her duties and does not act on the basis of false information knowing it to be false.

13.4.2 For Providing Information. No Representative or Third Party, as applicable, shall be liable to a Practitioner for damages or other relief by reason of providing Information, including otherwise privileged or confidential Information, concerning a Practitioner provided that such Representative or Third Party acts within the scope of his/her duties and does not act on the basis of false information knowing it to be false and provided further that such Information is within the scope of duties of the recipient.

13.5. APPLICABILITY

13.5.1 The confidentiality requirements and immunity provided by this Article apply to all Information in connection with the activities of this Hospital or any other health care facility or organization or medical staff concerning, but not limited to:

(a) Applications for appointment and/or Privileges.

(b) Reappointment and/or regrant of Privileges

(c) Corrective action/summary suspension.

(d) Hearings and appellate reviews.

(e) Performance improvement/quality assessment activities.

(f) Utilization review activities.

(g) Peer review/professional practice evaluation activities.

(h) Other Hospital, committee, Medical Staff Department/Section, or Medical Staff activities related to monitoring and maintaining quality and efficient patient care, clinical competence, and professional conduct.

13.5.2 The Information referred to in this Article may relate to a Practitioner's qualifications for Medical Staff appointment and/or Privileges (*e.g.,* professional licensure, certification, education, training, clinical competency, judgment, conduct, character, ability to fully and competently exercise the Privileges requested, professional ethics, *etc.*) or any other matter that might directly or indirectly affect the quality, efficiency, or appropriateness of patient care.

13.6. CUMULATIVE EFFECT

Provisions in the Medical Staff governing documents and in application forms for Medical Staff appointment and/or Privileges relating to authorizations, confidentiality of Information, releases, and immunity from liability are in addition to other protections provided by state and federal law and not in limitation thereof. A finding by a court of law or administrative agency with proper jurisdiction that all or any portion of such provision(s) is/are not enforceable shall not affect the legality or enforceability of the remainder of such provision(s) or any other provision(s).

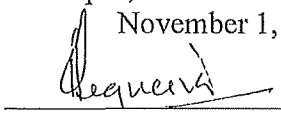
13.7. INDEMNIFICATION

13.7.1 To the fullest extent permitted by the laws of the State of Ohio, the Hospital shall indemnify and hold harmless all Medical Staff officers, Department Chairs/Section Chairs, committee members/chairs and Medical Staff Members who perform in good faith and without malice, functioning as agents of the Hospital, from and against any monetary settlements made or judgments rendered against such

persons; provided, however, that such indemnification shall not extend to any claims or legal proceedings made or brought against such persons which arise out of such person's acts outside the scope of the agency or which are committed in bad faith or with malice.

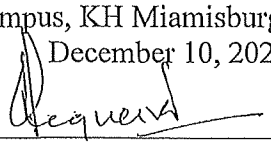
CERTIFICATION OF ADOPTION AND APPROVAL

Recommended by the Medical Executive Committee of
KH Main Campus, KH Miamisburg, and KH Troy on
November 1, 2024



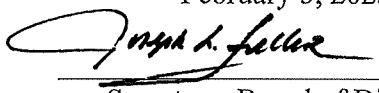
Chief of Staff

Adopted by the Medical Staff of
KH Main Campus, KH Miamisburg, and KH Troy on
December 10, 2024



Chief of Staff

Approved by the Board of
KH Main Campus, KH Miamisburg, and KH Troy on
February 5, 2025



Secretary, Board of Directors

CERTIFICATION OF ADOPTION AND APPROVAL

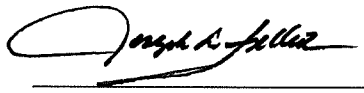
Recommended by the Medical Executive Committee of
KH Dayton and KH Washington Township on
November 25, 2024

Chief of Staff

Adopted by the Medical Staff of
KH Dayton and KH Washington Township on
December 14, 2024

Chief of Staff

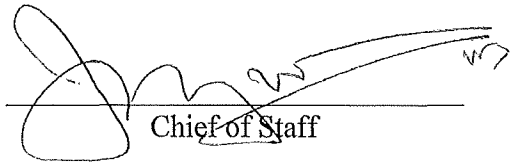
Approved by the Board of
KH Dayton and KH Washington Township on
February 5, 2025



Secretary, Board of Directors

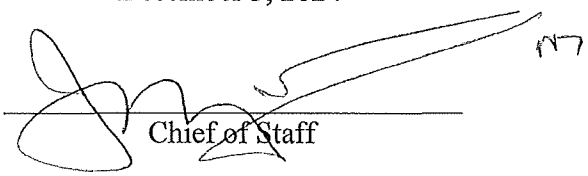
CERTIFICATION OF ADOPTION AND APPROVAL

Recommended by the Medical Executive Committee of
KH Greene Memorial and Indu & Raj Soin Medical Center on
November 22, 2024



Chief of Staff

Adopted by the Medical Staff of
KH Greene Memorial and Indu & Raj Soin Medical Center on
December 3, 2024



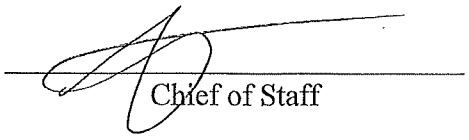
Chief of Staff

Approved by the Board of
KH Greene Memorial and Indu & Raj Soin Medical Center on
February 5, 2025

Secretary, Board of Directors

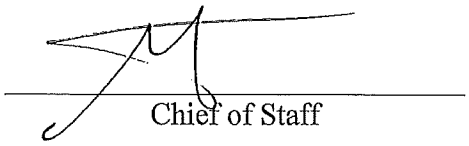
CERTIFICATION OF ADOPTION AND APPROVAL

Recommended by the Medical Executive Committee of
KH Hamilton on
November 8, 2024



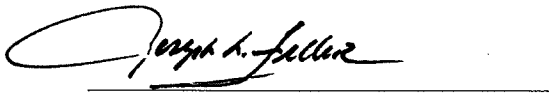
Chief of Staff

Adopted by the Medical Staff of
KH Hamilton on
December 11, 2024



Chief of Staff

Approved by the Board of
KH Hamilton on
February 5, 2025



Secretary, Board of Directors

Addendum A

KH Dayton/Washington Township
Medical Executive Committee Composition

Voting members:

- Chief of Staff (chair)
- Vice Chief of Staff
- Secretary/Treasurer
- Immediate Past Chief of Staff
- Three (3) members at large
- Department Chair of Anesthesiology
- Department Chair of Emergency Medicine
- Two (2) additional Department of Emergency Medicine representatives *(see attached)*
- Department Chair of Family Practice
- Two (2) additional Department of Family Practice representatives *(see attached)*
- Department Chair of Internal Medicine
- Section Chair of Cardiology
- One (1) additional Department of Internal Medicine representative *(see attached)*
- Department Chair of Neurology, Psychology, and Physical Medicine & Rehabilitation
- Department Chair of Obstetrics & Gynecology
- Department Chair of Pathology
- Department Chair of Pediatrics
- Department Chair of Radiology
- Department Chair of Surgery
- Section Chair of General Surgery
- Section Chair of Orthopedic Surgery
- Section Chair of Ophthalmology
- Section Chair of ENT
- Section Chair of Thoracic-Cardiovascular Surgery
- Clinical Quality Review Committee chair

Any individual who, by virtue of position, attends a meeting in more than one capacity shall be entitled to only one vote provided that such individual is eligible to vote.

***Ex Officio* (non-voting) members:**

- Hospital President
- Chief Medical Officer
- Credentials Committee chair

Guests:

- Chief Financial Officer
- Vice President(s) of Patient Care
- Vice President, Strategic Operations

Addendum A (*continued*)
KH Dayton/Washington Township
Procedure for Selection of Additional Department Representatives to the MEC

Qualifications: Additional Department representatives (*i.e.,* from the Departments of Emergency Medicine, Family Practice, and Internal Medicine as noted in the KH Dayton/Washington Township MEC composition above) shall be Practitioners appointed to the active Medical Staff category with Privileges or to the associate Medical Staff category without Privileges at the Hospital.

Conflicts of Interest. Additional Department representatives may not have a disqualifying Conflict of Interest. Additional Department representatives may not simultaneously hold a leadership and/or board position at another hospital other than such position at an Affiliate Hospital. Any Practitioner who is employed by or whose practice is owned/managed/operated by a competing hospital/healthcare entity (as determined by the Board or the Hospital President and/or Chief Medical Officer as authorized designees of the Board) is not eligible to serve as a Department representative and is obligated to disclose such conflicting interests. The obligation to disclose Conflicts of Interest is an ongoing obligation of a Practitioner who is nominated for and/or who holds an additional Department representative position on the KH Dayton/Washington Township MEC.

Nomination: The current Department Chair will issue a communication (in such manner as deemed appropriate) calling for nominations for the additional Department representative positions on the KH Dayton/Washington Township MEC. Nominations received from Department members eligible to vote on Department matters will be considered. All nominees for a Department Chair position shall, at the time of nomination, disclose to the Medical Executive Committee those personal, professional, or financial affiliations or relationships of which they are reasonably aware that could foreseeably result in a Conflict of Interest with their activities or responsibilities on behalf of the Medical Staff. In the event of such disclosure, the Hospital President and/or Chief Medical Officer (as authorized designees of the Board) will determine whether the Practitioner is eligible to run for an additional Department representative position. If a Practitioner with a Conflict of Interest is determined to be eligible to run for an additional Department representative position, the Conflict of Interest disclosure will be provided to the Medical Staff Department members eligible to vote when the approved nominations are communicated.

Election: Additional Department representatives will be elected in the same manner as set forth in Section 6.3.4 for Department Chairs.

Term: Additional Department representatives shall serve the same term as set forth in Section 6.5 for Department Chairs.

Vacancy: A vacancy in an additional Department representative position shall be filled in the same manner in which the original position was filled.

Resignation: Additional Department representatives may resign in the same manner as set forth in Section 6.6 for Department Chairs.

Removal: Additional Department representatives may be removed in the same manner as set forth in Sections 6.7 for Department Chairs.

References to "Department Chair" in Section 6.3.4 and Section 6.5-6.7 shall be read as "additional Department representative" for purposes of this Section.

Addendum B

KH Greene/Soin

Medical Executive Committee Composition

Voting members:

- Chief of Staff (chair)
- Vice Chief of Staff (Chief of Staff Elect)
- Secretary/Treasurer
- Immediate Past Chief of Staff
- Department Chair of Anesthesia
- Department Chair of Cardiology
- Department Chair of Emergency Medicine
- Department Chair of Imaging/Radiology
- Department Chair of Medicine
- Department Chair of Ob/Gyn
- Department Chair of Orthopedics
- Department Chair of Pathology
- Department Chair of Primary Care
- Department Chair of Surgery

Any individual who, by virtue of position, attends a meeting in more than one capacity shall be entitled to only one vote provided that such individual is eligible to vote.

***Ex Officio* (non-voting) members:**

- Hospital President
- Chief Medical Officer

Guests

- Chief Nursing Officer
- Chief Financial Officer
- CMIO

Addendum C
KH/Hamilton
Medical Executive Committee Composition

Voting members:

- Chief of Staff (chair)
- Vice Chief of Staff
- Secretary/Treasurer
- Immediate Past Chief of Staff
- Department Chair of Anesthesia
- Department Chair of Emergency Medicine
- Department Chair of Medicine
- Department Chair of Pathology
- Department Chair of Ob/Gyn & Pediatrics
- Department Chair of Radiology
- Department Chair of Surgery
- Credentials Committee chair
- Three (3) MEC members at large
- Trauma Medical Director

Any individual who, by virtue of position, attends a meeting in more than one capacity shall be entitled to only one vote provided that such individual is eligible to vote.

***Ex Officio* (non-voting) members:**

- Hospital President
- Chief Medical Officer

Guests:

- Chief Nursing Officer
- Chief Financial Officer
- CMIO

Addendum D

KH Main/Miamisburg/Troy
Medical Executive Committee Composition

Voting members:

- Chief of Staff
- Vice Chief of Staff/Elect (Chief of Staff Elect)
- Vice Chief/Credentials
- Vice Chief/CQRC
- Immediate Past Chief of Staff
- Department Chair of Anesthesia
- Department Chair of Cardiology
- Department Chair of Emergency Medicine
- Department Chair of Family Medicine
- Department Chair of Hospital Medicine
- Department Chair of Internal Medicine
- Department Chair of Medical Imaging
- Department of Ob/Gyn
- Department of Orthopedics
- Department of Pathology
- Department of Pediatrics
- Department of Surgery

Any individual who, by virtue of position, attends a meeting in more than one capacity shall be entitled to only one vote provided that such individual is eligible to vote.

***Ex Officio* (non-voting) members:**

- Hospital President/KH Main
- Hospital President/KH Miamisburg
- Hospital President/KH Troy
- Chief Medical Officer
- AMA and OSMA designated representatives

Guests:

- Chief Nursing Officer
- Chief Financial Officer