

**BYLAWS OF THE MEDICAL STAFF
OF
BROWARD HEALTH**

FIRST SET OF AMENDMENTS TO MAY 30, 2013 MEDICAL STAFF BYLAWS

BOARD APPROVED July 30, 2014



David DiPietro

JOINT CONFERENCE COMMITTEE APPROVED January 29, 2014 (Chaired by Comm. Wright)

UNIFIED MEDICAL STAFF COMMITTEE APPROVED January 29, 2014 (combined meeting)

BYLAWS COMMITTEE APPROVED

9/11/2013 AND 12/4/2013

MEDICAL STAFF BYLAWS COMMITTEE PROPOSED BYLAWS

1. Corrective revision to Sec 2.4, titled NONDISCRIMINATION, to include age as additional classification:

2.4 NONDISCRIMINATION

No person shall be denied appointment or clinical privileges on the basis of gender, age, race, religion, creed, national origin, sexual orientation, or handicap status, nor shall such standards operate to deny or prevent clinical privileges in an arbitrary, unreasonable, or capricious manner.

2. Corrective revision to definitional section titled Allied Health Professional (AHP), to remove clinical psychologist from categories of AHP's eligible for privileges as prior amendment reclassified clinical psychologists to Consulting Medical Staff Membership Category.

Allied Health Professional (AHP): An individual who is not a practitioner as defined herein, but who is qualified by academic and clinical training to function in a medical support role and who may provide service under the direction and supervision of a member of the Medical Staff or who may independently provide services, as requested by a member of the Medical Staff. An Allied Health Professional provides direct patient care services in the Hospital while exercising judgment within the areas of documented professional competence and consistent with applicable law. AHPs are designated by the Board to be credentialed through the Medical Staff system and are granted clinical privileges as either a dependent or independent health care professional as defined in these Bylaws. The Board has determined the following categories of individuals eligible for clinical privileges as an AHP: physician assistant (PA), anesthesiology assistant (AA), advanced registered nurse practitioner (ARNP, certified registered nurse anesthetist (CRNA), certified nurse midwife (CNM) ~~and clinical psychologist.~~

3. Re-write of Section 2.1.7.2, titled BOARD CERTIFICATION:

2.1.7.2 BOARD CERTIFICATION

Each new applicant for membership at any Hospital of Broward Health, at the time of appointment must be Board Certified by the American Board of Medical Specialties (ABMS), American Osteopathic Association (AOA), American Board of Podiatric Surgery (ABPS), or American Board

of Oral/Maxillofacial Surgeons (ABOMS) in the applicable general or subspecialty area for which the applicant seeks privileges within seven (7) years of the completion of his or her post-graduate medical training ("Last Completion Date").

Each new licensed psychologist applicants for membership at any Hospital of Broward Health at the time of appointment must be Board Certified by the American Board of Psychology in the applicable general or subspecialty area for which the applicant seeks privileges within seven (7) years from January 1, 2014 or within seven (7) years of completion of his or her post-graduate training, whichever is later ("Psychologist Last Completion Date").

If a Member fails to attain Board Certification as specified above by the applicable Last Completion Date, then such failure shall be deemed an automatic, voluntary resignation of the applicable privileges effective the Last Completion Date. Notice of the Member's Board Certification status shall be given by the Medical Staff Office to the Member at the time of initial appointment, reappointment and six and two months prior to the applicable Last Completion Date. The notice given six months prior to the applicable Last Completion Date shall be sent by certified mail.

If a new applicant for membership is already Board Certified, then he or she shall present evidence establishing that he or she meets the above specified criteria for Board Certification at the time of appointment.

Such requirement for new applicants shall not apply to or affect existing Members of the Medical Staff at the Hospital at which they have continually been a Member prior to April 1, 2006, or met the requirements for Board Certification as a condition of membership at the Hospital at which they are already a Member. For licensed psychologists who have continually been a Member prior to January 1, 2014, the Last Completion Date for obtaining Board Certification as specified above shall be seven (7) years from January 1, 2014.

Board Certification for Medical Staff Officers will be in compliance with current Joint Commission requirements.

**BROWARD HEALTH
MEDICAL STAFF BYLAWS**

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PREAMBLE

The goal of the Medical Staff is to provide the best possible care for all patients admitted to, or treated in, any of the Broward Health facilities.

The Medical Staff recognizes and accepts the privileged responsibility to come together as a cohesive organization, ensuring the highest quality of medical care in the hospitals and facilities of Broward Health.

Therefore, we the physicians practicing in the facilities of Broward Health, hereby organize ourselves into self-governing Medical Staffs in conformity with the Bylaws herein stated.

It is the general intent of these Bylaws that the criteria and processes for the consideration and determination by the Medical Staff of Medical Staff membership, medical credentials, clinical privileges and the due process afforded to practitioners relating to such issues shall be as uniform among the Broward Health hospitals and facilities as reasonably practicable.

DEFINITIONS OF TERMS

The following terms shall have the meanings as set forth below, unless the context clearly indicates otherwise. Some of the terms defined below are not capitalized when used throughout these Bylaws.

Administration: The executive members of the Hospital staff including, but not limited to, the Chief Executive Officer (CEO), Chief Operating Officer (COO), Chief Financial Officer (CFO), Chief Nursing Officer (CNO).

Administrator: The individual appointed by the Corporate Chief Executive Officer to act on behalf of the Hospital in the overall management of the Hospital. The administrator holds the title of Chief Executive Officer (CEO) of the Hospital. In the event of his/her absence, the CEO may select a designee to temporarily serve in the role of administrator.

Adverse Action: An adverse action shall entitle the individual to the procedural rights afforded by these Bylaws, including the Fair Hearing and Appellate Review Procedures set forth in Article VI, which encompass the Fair Hearing Plan. An adverse action shall include a denial or termination of Medical Staff membership, or a denial, reduction, or termination of clinical privileges, except as otherwise provided in these Bylaws.

Allied Health Professional (AHP): An individual who is not a practitioner as defined herein, but who is qualified by academic and clinical training to function in a medical support role and who may provide service under the direction and supervision of a member of the Medical Staff or who may independently provide services, as requested by a member of the Medical Staff. An Allied Health Professional provides direct patient care services in the Hospital while exercising judgment within the areas of documented professional competence and consistent with applicable law. AHPs are designated by the Board to be credentialed through the Medical Staff system and are granted clinical privileges as either a dependent or independent healthcare professional as defined in these Bylaws. The Board has determined the following categories of individuals eligible for clinical privileges as an AHP: physician assistant (PA), anesthesiology assistant (AA), advanced registered nurse practitioner (ARNP), certified registered nurse anesthetist (CRNA), certified nurse midwife (CNM) and clinical psychologist..¹

Applicant: An individual who has submitted a Complete Application for appointment, reappointment or clinical privileges.

Board Certification: A designation for a physician who has completed an approved educational training program and an evaluation process including an examination designed to assess the knowledge, skills and experience necessary to provide quality patient care in that specialty. Board certification shall be from an American Board of Medical Specialties (ABMS); Member Board or the American Osteopathic Association

¹ §395.0191(2)(a), F.S.; §395.0191(2)(c), F.S.

(AOA); the American Board of Podiatric Surgery (ABPS) or the American Board of Oral/Maxillofacial Surgeons (ABOMS), as applicable.

Board of Commissioners: As used herein, the Board of Commissioners is the statutorily designated local governing body of the North Broward Hospital District, defined under chapter 1951-27438, and chapter 2006-347, Laws of Florida, delegated specific authority and responsibility, and appointed by the Governor of the State of Florida. It is the “governing body” as described in the standards of the Joint Commission and the Medicare Conditions of Participation. The Board of Commissioners may also be referred to as the “Board” or “Governing Body” unless otherwise specifically stated.

Broward Health: The special tax District in Broward County created and incorporated by the Legislature of the State of Florida legally known as the North Broward Hospital District and currently doing business as (d/b/a) Broward Health.

Bylaws: The Bylaws of the Medical Staff, unless otherwise specifically stated.

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

Chief of Staff: A member of the active Medical Staff who is elected by the voting members of the medical staff for each of the Hospital’s within the Broward Health health care system.

Clinical Privileges: Authorization granted by the Board to appropriately licensed individuals to render specifically delineated professional, diagnostic, therapeutic, medical, surgical, psychological, dental, or podiatry services in the Hospitals based on an individual’s license, education, training, experience, health status and judgment. Clinical privileges permit a Medical Staff member or, as appropriate, an Allied Health Professional, to render specific services to patients and include the right of access, as appropriate, to hospital resources, equipment, facilities, and personnel necessary to render such services.

Complete Application: An application for either initial appointment or reappointment to the Medical Staff, or an application for clinical privileges, that meets the requirements of these Bylaws.

Contract Practitioner: A practitioner providing care or services to Hospital patients through a contract or other legally binding arrangement.

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

Data Bank: The National Practitioner Data Bank (NPDB) implemented pursuant to the HCQIA.

Days: Calendar days, unless otherwise noted.

Dentist: An individual, who has received a doctor of dental surgery or a doctor of dental medicine degree from a dentistry program accredited by the Commission on Dental Accreditation (CODA) and has a current, unrestricted Florida license to practice dentistry.

Dependent Healthcare Professional: An individual who is permitted both by law and by the Hospital to provide patient care services under the direct supervision of a licensed independent practitioner, within the scope of the individual's license, and in accordance with individually granted clinical privileges if the dependent practitioner is an AHP.²

Department: A clinical grouping of members of the Medical Staff in accordance with their specialty or major practice interest, as specified in these Bylaws.

Disruptive Conduct: Conduct which adversely impacts the operation of the Hospital, affects the ability of others to get their jobs done, creates a "hostile work environment" for hospital employees or other individuals working in the Hospital, or begins to interfere with the disruptive individual's own ability to practice competently as more specifically identified the Disruptive Conduct policy referenced herein..

Executive Committee/Medical Executive Committee (MEC): Referred to as Medical Executive Committee, the group of the Medical Staff officers and department officers who represent the Medical Staffs and carry out the duties and key functions of Medical Staff governance and planning as prescribed by these Bylaws.

Ex Officio: Service as a member of a Committee or other organized body by virtue of an office or position held, and unless otherwise expressly provided, such service shall not include voting rights.

Fair Hearing Plan and Appellate Review Procedures: The due process and related rights and procedures incorporated into Article VI of these Bylaws.

Federal Health Care Program: Any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded directly, in whole or in part, by the United States Government or a State health care program (with the exception of the Federal Employees Health Benefits Program).³ The most significant Federal health care programs are Medicare, Medicaid, Blue Cross Federal Employee Program (FEP)/Tricare and the Veterans programs.

² 42 C.F.R. §482.12(c)(2)

³ Section 1128B(f) of the Social Security Act

Good Standing: The term “good standing” means a staff member who, during the current term of appointment, has maintained qualifications for Medical Staff membership and assigned staff category, has met attendance and participation requirements, is not in arrears in dues payment or the completion of medical records, and has not received notice of suspension or restriction of membership or privileges nor is the subject of any pending action that could result in suspension or restriction of membership or privileges.

Governing Body or Board: The Board of Commissioners of the North Broward Hospital District, which has been delegated specific authority and responsibility as set forth in Chapter 1951-27438, 2006-347, and 2007-299, Laws of Florida. .

GSA List: The General Service Administration’s List of Parties Excluded from Federal Programs.

HCQIA: The Health Care Quality Improvement Act of 1986, 42 U.S.C.S. §11101 et seq.

Hospital: All of the settings, services, and locations licensed or accredited as part of Broward Health acute care facilities, unless otherwise noted.

House Staff: House Staff are physicians who have received an appointment at one of the hospitals of Broward Health for educational purposes at the intern, resident or fellow level of training.

Independent Healthcare Professional: An individual who is permitted by both the applicable state law(s) and by the Hospital to provide patient care services without direction or supervision, within the scope of the individual’s license and in accordance with individually granted clinical privileges.⁴

Ineligible Person: Any individual who: (1) is currently excluded, suspended, debarred, or ineligible to participate in any Federal health care program; or (2) has been convicted of a criminal offense related to the provision of health care items or services; and has not been reinstated in a Federal health care program after a period of exclusion, suspension, debarment, or ineligibility.

License: An official or a legal permission, granted by a legally recognized authority, usually public, to an individual to engage in a practice, an occupation or an otherwise lawful activity.

License Status: Indicates the status of the physician’s medical license, which is issued by the state medical board. The most common status categories are:⁵

- active – full and unrestricted license to practice medicine
- inactive – physician is not practicing, but reserves the right to activate their license in the future

⁴ 42 C.F.R. §482.12(c)(1); 42 C.F.R. §482.12(c)(4)

⁵ Federation of State Medical Boards, Consumer Guide to Using Physician Profiles, <http://www.fsmb.org/>

- expired – no longer valid for use
- revoked – disciplinary action prohibits the practice of medicine
- restricted – board imposed limitation on the practice of medicine.

Licensure: A legal right that is granted by Florida's governmental agency in compliance with a statute governing the activities of a profession.⁶

Medical Staff, Organized: The body of individuals who, as a self-governing group, are responsible for establishing the Bylaws and Rules and Regulations, and policies for the Medical Staff at large and for each of the Medical Staffs at the hospitals comprising the Broward Health system. The Organized Medical Staff is limited to Practitioners who are Medical Staff members in the Active category of membership and have therefore been granted the rights to vote, to be a member of a Medical Staff committee, and to hold office in the Organized Medical Staff.

Medical Staff Office: The Broward Health employee(s) or contractor assigned the responsibility for processing applications for Medical Staff appointments, reappointments, and requests for clinical privileges, assisting in related peer review functions, for maintaining documents related to credentialing, peer review and other business of the Medical Staff and assisting in the administration of the Medical Staff's business. Medical Staff Office responsibilities are assigned by Administration and the Hospital employee(s)/contractor who works in the Medical Staff Office is accountable to Administration as his or her employer. The documents maintained by the Medical Staff Office are the property of the Hospital and shall be available to the Medical Staff in the conduct of its business.

Medical Staff Year: The term, "Medical Staff Year," shall be May 1 through April 30 of each year

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

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

Non-Privileged Practitioner: Those individuals who are licensed and who may order specific tests and services but who are not Medical Staff members.

OIG Sanction Report: The HHS/OIG List of Excluded Individuals/Entities.

Oromaxillofacial Surgeon Qualified: An individual who has successfully completed a postgraduate program in oral and maxillofacial surgery accredited by the Commission on Dental Accreditation (CODA).

⁶ Chapter 456, F.S.

Patient Contact: The term, "Patient Contact," will refer to any combination of inpatient admissions, emergency department encounters, ambulatory surgery cases, invasive procedures, consultations and evaluation for any such procedure which includes, but is not limited to, a written history and physical.

Primary Facility: The term "Primary Facility" shall refer to the hospital facility designated by the Physician as his/her primary facility in the event a Physician otherwise meets the definition of Active Primary at more than one hospital facility and has the requisite minimum number of patient contacts to be classified as an Active member of Medical Staff at either hospital. Such election may be made by the Physician only at the time of initial appointment and at each reappointment period.

Practitioner/Licensed Independent Practitioner (LIP): The term, "Practitioner/Licensed Independent Practitioner (LIP)" shall refer to the individuals who provide direct patient care in the Hospital, exercising judgment within the areas of documented professional competence and consistent with applicable law. These are individuals who are designated by the State and by the Hospital to provide patient care independently. The Board has determined that the categories of individuals eligible for clinical privileges as a LIP are medical doctors (MD), osteopathic physicians (DO), dentist (DDS), maxillofacial/oral surgeons (DMD), or a podiatrist (DPM)⁷ member of the Medical Staffs of the North Broward Hospital District.

Peer/Professional Review: The concurrent or retrospective review of an individual's performance of clinical professional activities by peer(s) through the procedures set forth in the Bylaws and applicable Medical Staff approved policies.

Physician: An individual who has been educated and trained in the practice of medicine, and who holds a current Florida license as a Doctor of Medicine (MD) or Doctor of Osteopathy (DO).

Podiatrist: An individual who holds a current Florida license as a Doctor of Podiatric Medicine (DPM).

Privileges: Authorization granted by the Board to an individual to provide specific patient care services in Broward Health as defined by Article 4.⁸

Proctor/Proctoring: Clinical proctoring is an objective evaluation of a Practitioner's actual clinical competence and/or professional competencies by a monitor or proctor who represents the Medical Staff and is responsible to the Medical Staff.

Professional Review Activity: Any activity of the hospital with respect to an individual Practitioner/LIP (i) to determine whether an applicant or Medical Staff member may have clinical privileges at the hospital or membership on the Medical Staff; (ii) to determine the scope or conditions of such privileges or membership; (iii) to change or

⁷ 42 C.F.R. §482.12(a)(1); 42 C.F.R. §482.12(c)(1)

⁸ MS.06.01.07

modify such privileges or membership; (iv) any action taken pursuant to Article V; (v) any action taken pursuant to Article VI; (vi) any focused and ongoing professional practice evaluations, quality assessment and performance improvement in accordance with these Bylaws.

Professional/Peer Review Body: Any person, committee, or entity having authority to make an adverse recommendation with respect to or to take or propose an action affecting or involving any applicant or Medical Staff member in furtherance of a Professional Review Activity. A Professional Review Body may include, but not be limited to, the Board of Commissioners, the Unified Medical Staff Committee, the MEC, the Credentials and Qualifications Committee, any Ad Hoc Investigation Committee, any Hearing Committee, any Appellate Review Committee, the Chief Executive Officer of the hospital, the President/Chief Executive Officer of Broward Health, and/or the Chief of Staff and Department Chairs of the hospital.

Qualified Physician: A Doctor of Medicine (MD) or a Doctor of Osteopathy (DO) who, by virtue of education, training and demonstrated competence, is granted clinical privileges by the Hospital to perform specific diagnostic or therapeutic procedure(s) and who is fully licensed to practice medicine.⁹

Registration: The process in which a person licensed to practice by a federal or state authority has such a license recorded or registered.

Rules and Regulations: The Rules and Regulations of the Medical Staff including those of its Departments and Divisions as approved by the Unified Medical Staff Committee and the Board of Commissioners with respect to such Rules and Regulations applicable at all Broward Health hospitals and with respect to such Rules and Regulations that are of limited applicability to a specific Hospital as approved by the applicable MEC and Board of Commissioners.

Section: A clinical sub grouping of members of a Medical Staff Department in accordance with their subspecialty or specialized practice interest, as specified in these Bylaws.

Staff: Unless otherwise specifically stated, the Medical Staff of the applicable Hospital.

State: The State in which the Hospitals of Broward Health operate and are licensed to provide patient care services, which is Florida.

Telemedicine: Medical practice is defined as any contact that results in a written or documented medical opinion and affects the medical diagnosis or medical treatment of a patient.¹⁰ Telemedicine is the practice of medicine through the use of electronic communication or other communication technologies to provide or support clinical care

⁹ Joint Commission Comprehensive Accreditation Manual for Hospitals (CAMH), Glossary

¹⁰ Definition of the Federation of State Medical Boards

at a distance.¹¹ Joint Commission and the American Telemedicine Association further define telemedicine as the use of medical information exchanged from one site to another via electronic communications for the health and education of the patient or healthcare provider and for the purpose of improving patient care, treatment and services.¹²

CONSTRUCTION OF TERMS AND HEADINGS

All pronouns and any variations thereof in these Bylaws and Rules and Regulations shall be deemed to refer to the masculine, feminine, or neuter, singular or plural, as the identity of the person or persons may require, unless the context clearly indicates otherwise.

ARTICLE I. NAME, PURPOSES, AND RESPONSIBILITIES

1.1. NAME

The name of this organization shall be the “Medical Staffs of Broward Health” which shall include the Medical Staffs of Broward General Medical Center, North Broward Medical Center, Imperial Point Medical Center and Coral Springs Medical Center, the four of which comprise the Medical Staffs of Broward Health.¹³

1.2. PURPOSES AND RESPONSIBILITIES

The purposes and responsibilities of the organized Medical Staffs are:

1.2.1. To provide a formal organizational structure for self-governance through which the organized Medical Staffs shall carry out their responsibilities and oversee the professional quality of all health care provided to patients in the Hospital by Practitioner/Licensed Independent Practitioners. These Bylaws shall reflect the current organization and functions of the Medical Staffs;¹⁴

1.2.2. To serve as a primary means of accountability for recommendations to the Board concerning professional performance of Practitioners/Licensed Independent Practitioners with clinical privileges authorized to practice at Broward Health with regard to the quality and medical appropriateness of health care;¹⁵

¹¹ MS.01.01.01 – MS.01.01.03

¹² Joint Commission Comprehensive Accreditation Manual for Hospitals

¹³ Chapter 206-347, Laws of Florida

¹⁴ LD.01.05.01; MS.01.01.01; 42 C.F.R. §482.22(b)(1); 42 C.F.R. §482.22(c)(3); 42 C.F.R. §482.12(a)(3); 59A-3.275, F.A.C.

¹⁵ LD.01.05.01; MS.01.01.01; 42 C.F.R. §482.22(b)(1); 42 C.F.R. §482.22(c)(3)

- 1.2.3. To provide mechanisms for recommending to the Board the appointment and reappointment of qualified Practitioners/LIPs, Independent Healthcare Professionals and AHPs and making recommendations regarding clinical privileges for such designated individuals which shall be followed absent good cause or determination such recommendation is not in compliance with these Bylaws;¹⁶
- 1.2.4. To provide education to the members of the Medical Staffs that will assist in maintaining patient care standards and encourage continuous advancement in professional knowledge and skills;
- 1.2.5. To initiate, adopt and maintain Rules and Regulations and policies for the proper functioning of the Medical Staffs;
- 1.2.6. To oversee and review medical research;
- 1.2.7. To provide a means whereby important and salient issues concerning the Hospitals may be discussed by the organized, independent Medical Staffs and, when appropriate, with, Administration, and/or the Governing Body;¹⁷
- 1.2.8. To collaborate in identifying community health needs and establishing appropriate institutional goals;¹⁸
- 1.2.9. To serve as a Professional Review Body in conducting Professional Review Activities, which include, but are not limited to, focused and ongoing professional practice evaluations, quality assessment, performance improvement, and peer review;¹⁹
- 1.2.10. To pursue corrective actions with respect to members of the Medical Staff or those individuals granted clinical privileges, when warranted;
- 1.2.11. To monitor and enforce compliance with these Bylaws, the Rules and Regulations of the Medical Staffs and Medical Staff approved policies;
- 1.2.12. To maintain compliance of the Medical Staffs with regard to applicable accreditation and licensure requirements and mandated provisions of applicable Federal, State, and local laws and regulations;²⁰

1.3. PRIVACY PRACTICES

¹⁶ MS.01.01.01

¹⁷ MS.01.01.01; MS.03.01.03; MS.04.01.01; LD.02.01.01; LD.03.04.01

¹⁸ LD.02.01.01; LD.03.02.01; LD.03.03.01; LD.04.03.01; LD.04.03.01

¹⁹ 42 C.F.R. §482.12(a)(5); MS.05.01.01; MS.08.01.01; MS.08.01.03; MS.09.01.01; §395.0193, F.S.

²⁰ LD.04.01.01; 42 C.F.R. §482.11(a)

- 1.3.1. Each member of the Medical Staff, as well as every Practitioner or Allied Health Professional with clinical privileges and each Practitioner with temporary privileges (collectively herein referred to as the "Provider" in this paragraph), shall be part of the Organized Health Care Arrangement with the Hospital, which is defined in 45 C.F.R. §164.501, (commonly known as the HIPAA Privacy Regulations) as a clinically-integrated care setting in which individuals typically receive health care from more than one healthcare provider. This arrangement allows the Hospital to share information with the Provider and the Provider's office for purposes of the Provider's payment and practice operations and to render medical care. The patient will receive the Notice of Privacy Practices during the Hospital's registration or admissions process, which shall include information about the Organized Health Care Arrangement with the Medical Staff, Practitioners or Allied Health Professionals with clinical privileges, and Practitioners with temporary privileges.²¹

ARTICLE II. MEMBERSHIP, APPOINTMENT, REAPPOINTMENT

2.1. NATURE OF MEDICAL STAFF MEMBERSHIP AND GENERAL QUALIFICATIONS

The self-governing Medical Staffs include both the members of the Organized Medical Staff and such other members as delineated in these Bylaws consisting of those fully licensed Physicians/LIPs, Independent Healthcare Professionals permitted by law and by the Hospital to provide patient care dependently and independently within the Hospital, and whom the Board appoints as Members based upon the review and recommendations of the Medical Staffs.²² Staff membership is a privilege extended by the Board, and not a right of any above designated individual or any other person. Membership and/or the permission to exercise clinical privileges shall be extended only to individuals who continuously meet the requirements of these Bylaws and the applicable Rules and Regulations and Medical Staff approved policies.

The applicant's eligibility for staff membership or clinical privileges shall be in accordance with Chapter 395 of the Florida Statutes, titled Staff membership and clinical privileges, (Fla. Stat. 395.0191(4)/(5)).²³ All set standards and procedures applied by Broward Health and its Medical Staff in considering and acting upon application for staff membership and clinical privileges shall be available for public inspection.²⁴

²¹ 45 C.F.R. §164.501

²² LD.01.05.01; 42 C.F.R. §482.22(a); §395.0191(2)(a), F.S.; §395.0191(2)(c), F.S.

²³ §395.0191(4)/(5), F.S.

²⁴ §395.0191(5), F.S.

- 2.1.1. Medical Staff membership carries the responsibilities of monitoring and assessing the quality of care rendered by those privileged by the Medical Staffs.
- 2.1.2. Membership appointment will be to the Medical Staffs of Broward Health with a designated membership in one or more of the Medical. Each of the Medical Staffs of Broward Health may levy membership dues and appointment and reappointment fees for members as deemed appropriate for their individual facilities. In no instance shall such specific privileges be denied or restricted based on Broward Health's economic self-interest.
- 2.1.3. Specific privileges of the individual Medical Staff member for patient care will be determined as outlined in Article IV of these Bylaws, "Delineation of Privileges."
- 2.1.4. Patients may be admitted to the Hospital only on the orders of an appropriately credentialed Physician. All Hospital patients must be under the care of a member of the Medical Staff. All patient care shall be provided by or in accordance with the orders of a Medical Staff member rendering patient care within the scope of his or her granted privileges.²⁵

The categories of health care professionals eligible for Medical Staff membership and/or the granting of clinical privileges and the mechanism for appointment, reappointment and for the granting, renewing or revising of clinical privileges is as defined and set forth in these Bylaws, and approved by the Governing Body. Appointment to the Medical Staff or the granting of clinical privileges as recommended by the Medical Staff and granted by the Governing Body in accordance with these Bylaws shall be in accordance with the individual's Medical Staff category. The granting of membership or approval of appointment does not automatically confer the grant of privileges or any particular privileges and the decision to recommend the grant or denial of a privilege or privileges shall be consistently applied to all Practitioners applying for or holding that privilege based on objective review and assessment of the data gathered and applicable criteria.²⁶

2.1.5. LICENSURE

The applicant must possess a current, active (as defined in these Bylaws) license or certification in the State of Florida as a Doctor of medicine, osteopathic medicine, podiatry, dentistry, or oral/maxillofacial surgery, or as a physician assistant (PA), anesthesiology assistant (AA),

²⁵ 42 C.F.R. §482.12(a)(5), Interpretive Guidelines; 42 C.F.R. §482.12 (c)(1); MS.03.01.03

²⁶ MS.06.01.03; MS.06.01.07; MS.08.01.03

advanced registered nurse practitioner (ARNP), certified registered nurse anesthetist (CRNA), certified nurse midwife (CNM), or clinical psychologist.²⁷

2.1.6. CONTROLLED SUBSTANCE REGISTRATION

To have prescribing privileges for controlled substances, the applicant must possess a current Federal Drug Enforcement Administration (DEA) registration and be in compliance with any state regulations. Prescribing privileges shall be limited to the classes of drugs granted to the applicant by the DEA.²⁸

2.1.7. PROFESSIONAL EDUCATION AND TRAINING

2.1.7.1. The applicant must be a graduate of an approved, professional school recognized by the State Board as set forth in Section 18 (2)(a) of Chapter 2006 347, Laws of Florida, otherwise known as the “charter of the North Broward Hospital District”, as amended.

2.1.7.2. BOARD CERTIFICATION²⁹

Board Certification requirements will be defined by each Department and stated in the Rules and Regulations, but such requirements shall be uniform by Department at each Hospital of Broward Health. A Department shall require each new applicant for membership to be Board Certified by the American Board of Medical Specialties (ABMS), American Osteopathic Association (AOA), American Board of Podiatric Surgery (ABPS), or American Board of Oral/Maxillofacial Surgeons (ABOMS) in the applicable general or subspecialty area for which the applicant seeks privileges within seven (7) years of the completion of his or her post-graduate medical training and to maintain current certification or eligibility at the time of appointment. In the event that a new applicant for membership fails to attain Board Certification in the applicable general or subspecialty area of medicine within the prescribed time period, then such failure shall be deemed an automatic, voluntary resignation. In the event that a new applicant for membership is already Board Certified, then he or she may present evidence establishing existing Board Certification in the specialty area of medicine for acceptance into the applicable Department. Such requirement for new applicants

²⁷ MS.06.01.07; 42 C.F.R. §482.11(c); 42 C.F.R. §482.22(c)(4); §395.0191, F.S.

²⁸ MS.06.01.07

²⁹ 42 C.F.R. §482.12(a)(7)

shall not apply to or affect existing Departmental members at the hospital at which they have continually been a Member since prior to April 1, 2006 or met the requirements for Board Certification as a condition of membership at the hospital at which they are already a Member. Board Certification for Medical Staff Officers will be in compliance with current Joint Commission requirements.

2.1.8. CURRENT COMPETENCE, EXPERIENCE, CHARACTER, TRAINING, AND JUDGMENT

The applicant must demonstrate his/her individual character, health clinical competence, training, experience, and judgment with sufficient adequacy, as initially determined by the applicable Medical Staff Committees and as ultimately approved by the Board, to demonstrate that patients receiving healthcare services by the applicant will receive care of the generally recognized professional level of quality established by the Medical Staff and these Bylaws.³⁰ Evidence of current competence and experience shall include, but shall not be limited to, responses to related questions provided and information from training programs, peers, and other facility affiliations. In the case of an applicant for reappointment, evidence of current competence and experience shall also include, but not be limited to, documentation of continuing medical education, the results of performance improvement and peer review, and recommendation(s) provided by Department Chairperson(s).³¹

2.1.9. CONDUCT/BEHAVIOR

The applicant must be able to demonstrate the ability to work cooperatively with others and to treat others within the Hospital with respect. Evidence of ability to display appropriate conduct and behavior shall include, but shall not be limited to, responses to related questions provided and information from training programs, peers, and other facility affiliations. In the case of an applicant for reappointment, evidence of ability to display appropriate conduct and behavior shall also include, but not be limited to, a review of conduct during the previous term(s) of appointment and recommendation(s) provided by Department and Section Chairperson(s).

2.1.10. PROFESSIONAL ETHICS AND CHARACTER

The applicant shall agree to abide by the following, as applicable to his or her profession:

³⁰ MS.06.01.03; MS.06.01.07; MS.08.01.03; 42 C.F.R. §482.12; 42 C.F.R. §482.12(a)(6); 42 C.F.R. §482.22(c)(4)

³¹ MS.06.01.03; MS.06.01.07; 42 C.F.R. §482.12(a)(6); §395.0193, F.S.

- Principles of Medical Ethics of the American Medical Association, or the American Osteopathic Association;
- Code of Ethics of the American Dental Association, or American Podiatry Association;
- Provisions set forth under s.s. 456.063, F.S., as may be amended or supplemented by the State of Florida, governing licensed health care practitioners regarding sexual misconduct.
- Such other applicable ethical standards governing the applicant's profession or practice; and,
- Applicable provisions of the Code of Conduct of Broward Health and the code of ethical business and professional behavior adopted by the Board of Commissioners as set forth in Chapter 2007-299, Laws of Florida, as may be amended or supplemented by the State of Florida, as incorporated in these Bylaws or otherwise approved by the Medical Staff.³²

2.1.11. HEALTH STATUS/ABILITY TO PERFORM

The applicant shall possess the ability to perform the clinical privileges requested. In the event that the applicant has a physical or mental impairment that could possibly affect his/her ability to practice or competently carry out the clinical privileges requested, the applicant shall notify the Chief of Staff. Upon receipt of such notification, the Chief of Staff and the applicable Department Chair will meet with the applicant to determine the extent of the impairment. If it is determined that the impairment does not preclude or otherwise adversely affect the applicant's ability to competently perform the essential functions of the clinical privileges requested, the Chief of Staff and applicant will discuss whether there is a reasonable accommodation that would enable the applicant to competently perform such functions. If reasonable accommodation is necessary, the Chief of Staff will recommend to the CEO that the Hospital provide such accommodation to the extent required by law, or if not so required, as determined to be appropriate within the sole discretion of the Hospital.

2.1.12. COMMUNICATION SKILLS

The applicant shall possess an ability to communicate both verbally and in writing in English in an understandable manner sufficient for the safe delivery of patient care, as determined by Medical Staff as part of the appointment and reappointment review process. Hospital records, including patients' medical records, shall be recorded in a legible fashion, in English. Nothing in these Bylaws shall prohibit a Practitioner from communicating with a patient or his or her family in another

³² 42 C.F.R. §482.12(a)(6); LD.04.02.03 – LD.04.02.05; §464.018 (1)(m), F.S.

language consistent with any applicable Medical Staff approved policy or federal or state law.

2.1.13. FINANCIAL RESPONSIBILITY

The applicant shall document his or her compliance with the requirements of financial responsibility as set forth in F. S. 458.320 or 459.0085, or as may be amended or supplemented by the State of Florida in any manner authorized by said law.³³ This requirement may be modified appropriately to conform with the provisions within Chapter 456, F.S. allowing a physician acting as an officer, employee, or agent of the Federal Government or the state or its agencies or its subdivisions or the provisions set forth under s.s. 458.320 or s.s. 459.0085, F.S., governing financial responsibility.

2.1.15. CRIMINAL ACTIVITIES

An applicant may have his or her application for membership denied, modified or restricted and a member may have his or her Medical Staff membership or clinical privileges modified, restricted or revoked, when the individual has a conviction of, or a plea of guilty or no contest to any felony, or to any misdemeanor involving (i) controlled substances; (ii) illegal drugs; (iii) Medicare, Medicaid, or insurance or health care fraud or abuse; (iv) violence against another; (v) sexual misconduct; or (vi) the practice of a health care profession and/or the safety of patients and staff, even if not yet excluded, debarred, or otherwise declared Ineligible.

2.2. AVAILABILITY OF FACILITIES/SUPPORT SERVICES

An applicant may be denied specific clinical privileges if the Hospital is unable to provide adequate facilities and support services for the clinical privileges requested by the applicant or the attendant care of his/her patients. The Board may decline to accept, or notify the Medical Staff to cease or abate the review of applications for initial appointment, reappointment or requests for revision of clinical privileges in the event the applicable Hospital is unable to so provide adequate facilities, capacity or support services for the exercise of the specific privileges requested or such services are then currently provided in accordance with an exclusive services contract between Broward Health and a qualified provider, with such privileges performed pursuant to any such contract by appropriately credentialed members of the Medical Staff and/or such Independent Health Care Professional or Dependent Health Care Professional. The effect of such a denial or declination shall not constitute a denial of Staff membership or denial or restriction of clinical privileges, shall not entitle the affected applicant or member to any procedural rights of hearing or appeal, and shall not be reportable to the National Practitioner Data Bank.

³³ HCII recommended insurance requirements

2.3. EFFECTS OF OTHER AFFILIATIONS

No person shall be automatically entitled to Staff membership or to the exercise of clinical privileges merely because he/she is licensed to practice within his/her healthcare profession, is a member of any professional organization, is certified by any board, or has/had staff membership or clinical privileges in another non-Broward Health hospital or health care organization.³⁴

2.4. NONDISCRIMINATION

No person shall be denied appointment or clinical privileges on the basis of gender, race, religion, creed, national origin, sexual orientation, or handicap status, nor shall such standards operate to deny or prevent clinical privileges in an arbitrary, unreasonable, or capricious manner.³⁵

2.5. BASIC OBLIGATIONS ACCOMPANYING STAFF APPOINTMENT AND/OR THE GRANTING OF CLINICAL PRIVILEGES

By submitting an application for Staff membership and/or a request for clinical privileges, the applicant signifies agreement to fulfill the following obligations of holding Staff membership and/or clinical privileges. The applicant shall agree to:

- 2.5.1. Appear for any requested interviews regarding his/her application, or subsequent to appointment or the granting of clinical privileges, to appear for any requested interviews related to questions regarding his or her membership, status and qualifications, conduct, performance of his/her professional duties and to provide full and complete information with respect to any information request related to the initial or reappointment process made by the Medical Staff office or the Credentials and Qualifications Committee;
- 2.5.2. Provide continuous care to his/her patients³⁶ at the generally recognized professional level of quality established by the Medical Staff Bylaws, Rules and Regulations, Medical Staff approved policies and applicable community standards, and delegate in his/her absence the responsibility for diagnosis and/or care of his/her patients only to a Medical Staff member who is a member in good standing with same or like privileges and who is otherwise qualified to undertake this responsibility; and seek consultation whenever necessary;

³⁴ 42 C.F.R. §482.12(a)(7)

³⁵ LD.04.01.01; 59A-3.272, F.A.C.; §395.0191, F.S.; §395.0193, F.S.; §395.0195, F.S.

³⁶ MS.03.01.01

- 2.5.3. Read and abide by these Bylaws, the Rules and Regulations, and all other rules, policies and procedures, guidelines, and other requirements duly approved by the Medical Staff and Board;
- 2.5.4. Abide by all local, State, and Federal laws and regulations, Joint Commission standards, and State licensure and professional review regulations and standards, as applicable to the applicant's professional practice;
- 2.5.5. Regularly attend meetings of the Medical Staff in accordance with Staff category and Departmental requirements as delineated in the Medical Staff Rules and Regulation;
- 2.5.6. (Basis Obligations of Membership) Discharge such Medical Staff, Department, Section, Committee, and Hospital functions for which he/she is responsible based upon appointment, election, or otherwise, including as appropriate, providing on-call coverage for emergency care services within his/her clinical specialty, as required by the Medical Staff and/or as defined in any applicable contracted agreements;
- 2.5.7. Prepare and complete in a timely, legible manner the medical and other required records for all patients for whom he/she provides care in the Hospital and participate in necessary training and utilize the electronic record systems or other technology in use by the Hospital to prepare patient records;
- 2.5.8. Participate in peer review, quality assessment, performance improvement, risk management, case management/resource management, and other review and improvement activities if requested;
- 2.5.9. Participate in continuing medical education to maintain clinical skills and current competence;³⁷
- 2.5.10. Notify and update the Medical Staff and Hospital immediately within seven (7) business days upon a change in any qualifications for membership or clinical privileges including any change in the queries required in Section 2.7.3.14, as listed in these Bylaws or in any Rules and Regulations outlining criteria for clinical privileges including but not limited to becoming an Ineligible Person;
- 2.5.11. Agree that the Medical Staff may obtain an evaluation of the applicant's performance by a consultant selected by the Medical Staff if the Medical Staff considers it appropriate;

³⁷ MS.12.01.01; §456.031, F.S.; §456.032, F.S.

- 2.5.12. With the exception of the members of the Honorary categories of the Medical Staffs, a person shall reside, and for non-hospital based members, maintain an office, within a reasonable distance from each Broward Health Hospital at which he/she holds privileges. "Reasonable distance" shall be determined by the Medical Staff of each Hospital to insure timely care and be specialty specific;
- 2.5.13. Assure timely, competent professional care for patients in the Hospital by being personally available or designating a qualified alternate practitioner with the same or equivalent qualifications with whom prior arrangements have been made and who has clinical privileges to care for the patient at the hospital.;
- 2.5.14. Pay dues as required by the Medical Staff of each Hospital at which membership is granted.

2.6. TERMS OF APPOINTMENT

Initial appointments and initial granting of clinical privileges shall be for a period of up to one year (12 months), and subject to extension for a total period not to exceed two years (24 months).³⁸ Reappointments shall be for a period not to exceed two years (24 months).³⁹ In the event that reappointment has not occurred due to lack of submission of an application or submission of an incomplete application, within the specified time frames as defined within Section 2.7.2 of these Bylaws, the membership of the individual may be considered to have been voluntarily surrendered and membership expired. In such situations where the application is incomplete or has not been timely processed due to an act or conduct of the Medical Staff office the Medical Staff will take all reasonable steps to correct its processes and timely complete its review as may be permitted by law or regulation without requiring the Member to reapply. In such case, the individual shall be notified of the expiration of the term of membership and/or clinical privileges and the need to submit an application as a new applicant if continued or future membership or clinical privileges are desired. Voluntary surrender of membership and/or clinical privileges shall not entitle the individual to a fair hearing and appeal.

2.7. CREDENTIALS VERIFICATION AND APPLICATION PROCESSING PROCEDURES

2.7.1. NEW APPOINTMENT PRE-APPLICATION PROCESS

Upon receipt of a request to apply for Staff membership or clinical privileges, the Medical Staff Office shall screen the person requesting Staff membership or clinical privileges before an application is sent. The

³⁸ MS.06.01.07

³⁹ MS.06.01.07

person requesting Staff membership or clinical privileges shall be asked to supply documentation used to determine his/her eligibility to apply for membership or clinical privileges. The following information is required to determine eligibility:

- 2.7.1.1. Current license and/or certification to practice in Florida;
- 2.7.1.2. Current controlled substance registration, if prescribing medications;
- 2.7.1.3. Proof of compliance with the Financial Responsibility requirements set forth in Section 2.1.13 of these Bylaws;
- 2.7.1.4. Geographic location of office and residence;
- 2.7.1.5. National Provider Identifier (NPI);⁴⁰
- 2.7.1.6. Proof of meeting Board Certification requirements as defined in these Bylaws; and,
- 2.7.1.7. If the individual is able to provide the above listed evidence of qualifications, he/she shall be provided with an application form. Failure to provide the above listed information within six months after receipt of the application shall be deemed a voluntary cessation of the application process and shall not be considered an adverse action, and the individual shall not be entitled to any hearing or appeal rights under these Bylaws. Such determination will not result in the filing of a report with the state professional licensing board or with the National Practitioner Data Bank.

2.7.2. APPLICATION

A separate credentials file shall be maintained for each applicant for Staff membership or clinical privileges.⁴¹ Each application for Staff appointment, reappointment, and/or clinical privileges shall be in writing, submitted on the prescribed form, and signed by the applicant. When an individual is applying for initial appointment or is initially requesting clinical privileges, he/she shall be provided an application form when he/she is deemed eligible to apply, and shall also be given a copy of these Bylaws, and the applicable Medical Staff Rules and Regulations, and applicable Hospital policies approved by the Medical Staff.⁴² At least six months prior to expiration of the current term of membership or

⁴⁰ 45 C.F.R. §162.410 (Note: NPI is required effective May 23, 2007)

⁴¹ 42 C.F.R. §482.22(a)(2), Guidance to Surveyors

⁴² LD.02.01.01; LD.03.04.01

clinical privileges for an individual who is a member of the Medical Staff or who currently holds clinical privileges, the individual shall be sent a notice of the impending expiration and an application for reappointment and/or renewal of privileges. If the applicant has not responded within thirty days from the date such notice was sent, a certified letter shall be sent with such notice. The reappointment application must be received in the Medical Staff office and deemed complete 90 days prior to the expiration of the current appointment.

2.7.2.1. CONFIDENTIALITY OF MEDICAL STAFF FILES

The credentialing files of individual Medical Staff members are property of the Medical Staff within the custody of the Hospital and maintained in the Medical Staff office at each applicable Hospital and shall be confidential and shall not be disclosed except in accordance with the specific authorizations and purposes provided by these Bylaws. The member may review his/her file at any time at the Medical Staff office upon request and reasonable notice, with the exception of peer references and other peer information provided in confidence, such exception subject to the Fair Hearing process and the affected members participation and rights therein. Except when the Fair Hearing process is initiated, the affected member may not copy his/her file or receive copies of documents in the file except for documents the affected member originally provided as part of his or her application.

2.7.3. BURDEN ON APPLICANT

The applicant for appointment, reappointment, and/or clinical privileges shall have the burden of producing adequate information for a proper evaluation of his/her qualifications for membership or clinical privileges. Neither the Medical Staff nor the Board shall have any obligation to review or consider any application until it is complete, as defined in these Bylaws. The applicant shall provide accurate, up-to-date information on the application form, and shall be responsible for ensuring that all supporting information and verifications are provided, as requested. It shall be the responsibility of the applicant to ensure that any required information from his/her training programs, peer references, or other facilities is submitted directly to the Medical Staff Office by such sources. The applicant shall be responsible for resolving any doubts regarding the application. If during the processing of the application the Medical Staff or any of its committees or representatives thereof, determine that additional information or verification, or an interview with the applicant is needed, further processing of the application may be stayed and the application may not be considered complete until such additional information or verification is received, or

the interview is conducted. The Medical Staff Office shall notify the applicant of the specific information being requested, the timeframe within which a response is required, and the effect on the application if the information is not received timely.

Failure to provide a complete application, as defined in these Bylaws, within six months after being provided with an application form for initial appointment, or within the timeframe specified in Section 2.7.2 for reappointment or privileges, or failure to appear for any requested interview, shall be deemed a voluntary cessation of the application process. Voluntary cessation of the application process shall not be considered an adverse action, and shall not entitle the applicant to any hearing or appeal rights under these Bylaws. The Medical Staff Office shall provide written notice to an individual regarding his/her voluntary cessation of the application process for the reasons outlined herein. The completed application form shall include, without limitation:

- 2.7.3.1. Identifying information, including name, social security number, date of birth, any aliases, and addresses of office & residence, and presentment of a current government-issued photo ID for examination and photocopying by the Medical Staff Office, an original passport-type photograph, and any other reasonable identification required to verify identification requested by the Medical Staff office;
- 2.7.3.2. For new applicants, evidence of citizenship in the United States of America (e.g., birth certificate showing place of birth in the United States, naturalization papers, or U.S.A. passport), or evidence that the applicant is in the U.S.A. legally and has the required permission(s) to work in this country and licensed to practice in the State of Florida. A person is not disqualified from membership solely because he/she is not a United States citizen.⁴³ For applicants who are not U.S. citizens who are requesting reappointment or renewal of privileges, evidence of a current visa and current work permit shall be required, in accordance with all Broward Health Human Resources policies regarding work visas;⁴⁴
- 2.7.3.3. For a new applicant, written permission that the Medical Staff office may perform a third party background check when requested by the Medical Staff or its committee(s) or representative(s) participating in the credentialing process, and submission of any fees associated with processing a background check;

⁴³ §456.019, F.S.

⁴⁴ §456.019, F.S.

- 2.7.3.4. Evidence of current licensure in the State of Florida and information regarding any current or past licensure in any healthcare profession or in any other state;⁴⁵
- 2.7.3.5. For applicants requesting medication prescribing privileges, evidence of controlled substance registration(s), both federal DEA, and state, if applicable;
- 2.7.3.6. For a new appointment, the names and addresses of educational institutions, and dates of attendance, for undergraduate and postgraduate education (including research fellowships), including professional degrees earned, and in the case of a foreign graduate, ECFMG certificate;⁴⁶
- 2.7.3.7. For reappointments or renewal of clinical privileges, the applicant's participation in continuing education, specifically as related to the clinical privileges requested and required by Florida law;⁴⁷
- 2.7.3.8. The names of at least two peers who will provide information as to the applicant's medical/clinical knowledge; technical and clinical skills; clinical judgment; interpersonal and communication skills and professionalism The peer shall be someone with current knowledge of the applicant who can provide an unbiased appraisal (and preferably not a current partner in medical practice, spouse, or other family member), and who has known the applicant for a minimum of six months. For an applicant for reappointment, the applicant's Department Chairperson may serve as one of the peers, if he/she is a peer of the applicant;⁴⁸
- 2.7.3.9. Information regarding specialty board certification, if any, including the name of the specialty board(s), and dates of certification;
- 2.7.3.10. Information regarding all current and all past healthcare facility affiliations, including the name and address of the facility(s) and dates of affiliation;⁴⁹
- 2.7.3.11. Evidence of compliance with the Florida Physician Financial Responsibility statute;

⁴⁵ MS.06.01.03; MS.06.01.07; MS.08.01.03; 42 C.F.R. §482.22(a)(2)

⁴⁶ MS.06.01.03; MS.06.01.07; MS.08.01.03; 42 C.F.R. §482.22(a)(2)

⁴⁷ MS.12.01.01; §456.027, F.S.; §456.031, F.S.; §456.032, F.S.

⁴⁸ MS.06.01.03; MS.06.01.07; MS.08.01.03; MS.07.01.03; 42 C.F.R. §482.22(a)(2)

⁴⁹ MS.06.01.03

- 2.7.3.12. Medicare Provider NPI;
- 2.7.3.13. Information as to any current sanctions or pending investigations affecting the applicant's ability or authorization to participate in any Federal Health Care Program; or which might cause the applicant to become an Ineligible Person.
- 2.7.3.14. Accurate and complete disclosure with regard to the following queries:
 - 2.7.3.14.1. Whether the applicant's professional license or controlled substance registration (DEA, state or local), in any jurisdiction, has ever been disciplined, restricted, revoked, suspended, or surrendered, or whether such action is currently pending, or whether the applicant has voluntarily or involuntarily relinquished such licensure or registration in any jurisdiction;⁵⁰
 - 2.7.3.14.2. Whether the applicant has had any voluntary or involuntary termination of Medical Staff membership, or voluntary or involuntary limitation, reduction, loss, or denial of clinical privileges at another Hospital, and whether any such action or investigation is currently pending that could result in the termination of Medical Staff membership; limitation, reduction, loss or denial of clinical privileges at another Hospital;⁵¹
 - 2.7.3.14.3. Whether the applicant has had any notification of, or any involvement in, a professional liability claim or professional liability legal proceeding, including all current or former investigations of any such claim, and any final judgments or settlements involving the applicant; and,⁵²
 - 2.7.3.14.4. Whether the applicant has ever been convicted of or pled guilty or no contest to any criminal activity, as defined in Section 2.1.15 or whether any charge of said criminal activity is pending.

⁵⁰ MS.06.01.07

⁵¹ MS.06.01.07

⁵² MS.06.01.07

- 2.7.3.15. A statement from the applicant that he/she agrees to abide by the ethical code and standards governing his/her profession as referenced in Art. II, Sec. 2.1.10;
- 2.7.3.16. A statement from the applicant and the applicant's treating and/or primary physician that his/her health status is such that he/she has the ability to perform the clinical privileges that he/she is requesting, pursuant to Article II, Section 2.1.11;⁵³
- 2.7.3.17. Evidence that the applicant has complied with health and illegal substance screening requirements per the Broward Health HR policy or such other policy as adopted by the Medical Staff;
- 2.7.3.18. A statement from the applicant that he/she has received and read the current Staff Bylaws, Rules and Regulations and agrees to be bound by them, including any future Bylaws, Rules and Regulations and policies which may be duly approved by the Medical Staff;
- 2.7.3.19. A statement from the applicant as part of an initial application and application for reappointment consenting to the release and inspection of all records or other documents that may be material to an evaluation of his/her professional qualifications, including all health information and medical records necessary to verify the applicant's health status as required by Section 2.1.11, and for a new applicant, permission to conduct a background check, and a statement providing immunity and release from civil liability for all individuals requesting or providing information relative to the applicant's professional qualifications or background, or evaluating and making judgments regarding such qualifications or background;⁵⁴
- 2.7.3.20. A statement from the applicant agreeing that in the event of an adverse action concerning his/her Staff membership or clinical privileges, he/she will exhaust all remedies afforded by these Bylaws before resorting to formal legal action or commencing legal proceedings;
- 2.7.3.21. In the case of applicants for initial appointment to the Medical Staff, a signed Medicare Acknowledgement Statement;
- 2.7.3.22. Physicians/LIPs, other Independent Healthcare Professionals, and Allied Health Professionals will sign a Confidentiality and

⁵³ MS.06.01.03; 42 C.F.R. §482.22(c)(4)

⁵⁴ MS.12.01.01

Data Security Agreement at the time of application for initial appointment and during the reappointment process and shall agree that as a condition of membership or holding clinical privileges, the individual shall abide by the government mandated privacy policies applicable to the Hospital and/or Broward Health. Completed Agreements will be maintained in the individual's credentials file;

- 2.7.3.23. A specific written request for clinical privileges using prescribed forms.⁵⁵ Requests for clinical privileges shall not be complete unless it includes supporting evidence of competence for each of the privileges requested and proof that the applicant meets the criteria for each of the privileges requested;
- 2.7.3.24. As a condition of consideration for initial and continued appointment to the Medical Staff, agreement to immediately provide (within seven (7) business day of being officially notified of a change in status or otherwise being requested by the Medical Staff office) to the Medical Staff and the CEO of each Hospital at which the applicant or Member, as the case may be, is applying or a member of Medical Staff, any new or updated information that is pertinent to the individual's professional qualifications or any question on the application form, including but not limited to any change in Federal Health Care Program Ineligible Person status, any exclusion from a State Program, any change in licensure in any state, any change in DEA status, or any exclusion or other sanctions imposed or recommended by the Federal Department of Health and Human Services or the Florida Department of Health, the receipt of a FMQAI citation, any change in legal status to reside and/or work in the U.S.A., any investigation by any specialty or certifying board, any significant change in health status that could affect his or her ability to perform privileges requested or granted, any change in location of office, any change in contact information, any criminal activity as defined in Section 2.1.15, and any nonvoluntary termination, restriction or limitation on membership or privileges held at another health care facility;
- 2.7.3.25. In the event the applicant is a Physician/LIP who is a sponsoring Physician or an AHP for whom a sponsor is required, information as to the number of AHP's the sponsoring Physician sponsors and the number and specialty of Physicians under whom the applicant AHP will be providing

⁵⁵ 42 C.F.R. §482.22(a)(2)

patient care will be provided and must be in accordance with Florida law.

- 2.7.3.26. Information regarding an applicant's prior held privileges at any other health care facility at which the applicant currently or previously held privileges, including volumes and outcome..

2.7.4. VERIFICATION PROCESS

Upon the receipt of a completed application form, the Medical Staff Office shall arrange to verify the qualifications and obtain supporting information relative to the application. The Medical Staff Office shall consult primary sources of information about the applicant's credentials, where feasible.⁵⁶ Verifications of licensure, controlled substance registration, the query of the NPDB, and queries of the OIG and GSA lists shall be done within 90 days prior to the Board receiving the application; if there are delays in completing the application, any of these verifications that were done more than 90 days before the Board is scheduled to receive the application shall be repeated. Verification may be made by a letter or computer printout obtained from the primary source or it may be verbally or electronically transmitted (e.g., telephone, facsimile, email, Internet) information when the means of transmittal is directly from the primary source to the Hospital and the verification is documented. All Hospitals within Broward Health may share primary source verifications. If the primary source has designated another organization as its officially designated agent in providing information to verify credentials, the Hospital may use this other organization as the designated equivalent source.⁵⁷ The Medical Staff Office shall promptly notify the applicant of any problems in obtaining required information. Any action on an application shall be withheld until the application is completed; meaning that all information has been provided and verified, as defined in these Bylaws.⁵⁸ The following information shall be verified for all applicants for appointment, reappointment, or clinical privileges, except as specified:

- 2.7.4.1. Current licensure shall be verified in all states in which the applicant currently holds a license, including the State of Florida through the applicable state licensure boards for all applicants. For new applicants, current and past licensure in other states shall also be verified through those applicable state licensure boards.⁵⁹ For applicants for reappointment or renewal of privileges, any licenses that were in effect at the

⁵⁶ MS.06.01.03; Lees v. Asante Health Systems, No. CV 04-1804-MO (D. OR., Nov. 22, 2005); 45 C.F.R. §60.11(a)

⁵⁷ MS.06.01.03

⁵⁸ MS.06.01.03; MS.06.01.07; MS.08.01.03

⁵⁹ MS.06.01.03; MS.06.01.07; MS.08.01.03; 42 C.F.R. §482.22(a)(2)

time of the last appointment but are no longer in effect for any reason, shall be identified and the applicable state licensure board shall be contacted to verify circumstances regarding status and/or discontinuance of licensure;

- 2.7.4.2. For individuals requesting prescribing privileges, federal DEA registration shall be verified through the US Department of Commerce, National Technical Information Service's electronic verification mechanism;
- 2.7.4.3. For new applicants, completion of medical school or other post-graduate programs appropriate to the applicant's healthcare profession shall be verified through the school's registrar's office, or the National Student Clearinghouse if designated by the school to provide degree verification, and/or through the ECFMG in the case of a foreign medical school graduate.⁶⁰ The American Medical Association (AMA) profile, the American Osteopathic Association (AOA) profile and/or the Federation Credentials Verification Service (FCVS) profile may be used as a secondary source of information or as a primary source only when previous efforts to obtain the information have been exhausted. For applicants for reappointment or renewal of privileges, information about the topics and content of the applicant's continuing education shall be documented and considered as related to the privileges requested;⁶¹
- 2.7.4.4. For new applicants, their internship, residency, or other applicable postgraduate training, research, or employment shall be verified through the program's registrar's office, program director's office, or employer;⁶²
- 2.7.4.5. For new applicants, a background check, as defined by Broward Health policy, may be obtained when requested by the Credentials and Qualifications Committee or the Medical Executive Committee in connection with the credentialing process. The background check may be used in part to verify that the individual requesting approval is the same individual identified in the credentialing documents;⁶³
- 2.7.4.6. Information reported pursuant to the HCQIA shall be obtained from the National Practitioner Data Bank;⁶⁴

⁶⁰ MS.06.01.03; MS.06.01.07; MS.08.01.03; 42 C.F.R. §482.22(a)(2)

⁶¹ MS.12.01.01

⁶² MS.06.01.03; MS.06.01.07; MS.08.01.03; 42 C.F.R. §482.22(a)(2)

⁶³ MS.06.01.03

⁶⁴ 42 U.S.C. §11135; 45 C.F.R. §60.10

- 2.7.4.7. The OIG Sanction Report, the GSA List, and any state Exclusion List shall be checked to determine whether the applicant is listed;
- 2.7.4.8. For new applicants, information about the applicant's membership status shall be obtained from all health care facilities where the applicant has been granted clinical privileges. For applicants seeking reappointment or renewal or increase in clinical privileges information about the applicant's membership status shall be obtained from health care facilities where the applicant currently holds clinical privileges;
- 2.7.4.9. For reappointments, data and information regarding professional performance at the Broward Health hospitals at which the Member holds privileges at the time of reappointment shall be requested from available sources to facilitate the evaluation of each applicant's professional performance.
- 2.7.4.10. The applicant's health status as applicable to their ability to perform the clinical privileges requested shall be verified in accordance with Article II, Section 2.1.11.,⁶⁵
- 2.7.4.11. Three peer references shall be required for initial applicants. Two peer references shall be required for applicants for reappointment or renewal of clinical privileges; the Department Chairperson may serve as the second peer reference in such cases unless the Chairperson is not a peer, and then two peer references shall be required.⁶⁶ Peer recommendations shall include written information regarding the applicant's current medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, and professionalism, in the format prescribed by the Medical Staff office;⁶⁷ In addition to the peer references, one clinical non-peer and one non-clinical peer reference shall be required for both initial and reappointment or renewal of clinical privileges.
- 2.7.4.12. Each recommendation concerning the appointment of a member and/or the grant of clinical privileges shall be an evidence-based assessment, which will include a

⁶⁵ MS.06.01.03; MS.06.01.07; MS.08.01.03

⁶⁶ MS.06.01.03; MS.06.01.07; MS.08.01.03; MS.07.01.03; 42 C.F.R. §482.22(a)(2)

⁶⁷ MS.06.01.05

determination whether there is sufficient clinical performance information to make a decision to grant, limit, or deny the requested privileges.⁶⁸ For a new applicant or an applicant for reappointment or additional clinical privileges, the following information will be assembled and reviewed: number of cases, treatment results and conclusions drawn from quality assessment, performance improvement activities, interpersonal and communication skills as required for effective and professional interaction with patients, patient families and other health care providers and Administrators, history of compliance with Medical Staff approved policies regarding professional conduct, ethical practice, professional behaviors reflecting a sensitivity to diversity and a responsible attitude to patients, the medical profession and society.⁶⁹ Relevant applicant-specific information from organization performance improvement activities shall be considered and compared to aggregate information when evaluating professional performance, judgment, and clinical or technical skills at the time of reappointment, or renewal or revision of clinical privileges;⁷⁰

2.7.4.13. Specialty board certification shall be verified through consultation with the American Board of Medical Specialties (ABMS), the Bureau of Osteopathic Specialists (BOS), the American Board of Podiatric Surgery (ABPS) and the American Board of Oral/Maxillofacial Surgeons (ABOMS), or Allied Health Professional (AHP) certification, as applicable; and,

2.7.4.14. With regard to new applicants for Staff membership or clinical privileges, or applicants for reappointment who are not active at Broward Health, evidence of qualifications and competence shall be verified through correspondence with the Medical Staff offices of other health care facilities where the applicant is affiliated and currently practicing.⁷¹

2.7.5. APPLICATION PROCESSING

After verification is accomplished and the application is fully complete it shall be reviewed and processed as follows:⁷²

⁶⁸ MS.06.01.05; §395.0193(2)(g), F.S.

⁶⁹ *Lees v. Asante Health Systems*, No. CV 04-1804-MO (D. OR., Nov. 22, 2005)

⁷⁰ MS.06.01.07; 42 C.F.R. §482.22(a)(2)

⁷¹ MS.06.01.03; MS.06.01.07; MS.08.01.03; MS.07.01.03; 42 C.F.R. §482.22(a)(2)

⁷² MS.01.01.01; MS.06.01.07; MS.08.01.03

- 2.7.5.1. Department Report: The Medical Staff Office shall make available the application and all supporting materials to the Chairperson of each Department or his or her designee in which the applicant seeks privileges, and request the documented evaluation and recommendations as to the staff category, in the case of applicants for Staff membership, the Department to be assigned, the Section to be assigned if appropriate to the applicant's practice, the clinical privileges to be granted, and any concerns regarding the clinical privileges requested.⁷³ In the event that the applicant is the Department Chairperson, the Chief of Staff or the Department Vice Chairperson shall make the evaluation and recommendations. Following the Department Chairperson(s)' evaluation and recommendations, the report shall then be transmitted to the Credentials and Qualifications Committee. The time frame for completion of the Department report(s) shall be within 30 days of receipt of a complete application.⁷⁴
- 2.7.5.2. Credentials and Qualifications Committee Report: The Credentials and Qualifications Committee shall receive the evaluation and recommendations from the applicable Department and review the application, supporting materials, the report of the Department Chairperson or his or her designee, and any such other available information as may be relevant to the applicant's qualifications. The Credentials and Qualifications Committee shall prepare a written report and recommendations for the Medical Executive Committee as to Staff appointment and staff category in the case of applicants for Staff membership, the Department/Section to be assigned, the clinical privileges to be granted, and any special conditions to be placed on the membership status or clinical privileges to be granted. In the event there are any adverse recommendations, the reasons shall be stated. If the Credentials and Qualifications Committee deems it appropriate, it may arrange for a Physician who is not on the Medical Staff of the applicable Hospital but who specializes in the applicant's field to assist in its evaluation. The timeframe for completion of the Credentials and Qualifications Committee action shall be at the next regular meeting of the committee following receipt of the Department report.
- 2.7.5.3. Medical Executive Committee: The Medical Executive Committee shall receive from the Credentials and Qualifications Committee and review the application,

⁷³ MS.01.01.01; MS.06.01.07; MS.08.01.03; LD.04.01.05

⁷⁴ MS.01.01.01; MS.06.01.07; MS.08.01.03; LD.04.01.05

supporting materials, the report of the Credentials and Qualifications Committee, and any such other available information as may be relevant to the applicant's qualifications. The MEC shall make specific findings as to the applicant's satisfaction of the requirements of experience, ability, and current competence as set forth in these Bylaws.⁷⁵ The Medical Executive Committee shall prepare a written report and recommendations for the Board as to Staff appointment and staff category in the case of applicants for Staff membership, the Department/Section to be assigned, the clinical privileges to be granted, and any special conditions to be placed on the clinical privileges to be granted. In the event there are any adverse recommendations, the reasons shall be stated. The timeframe for completion of the Medical Executive Committee action shall be at the next regular meeting of the committee following receipt of the Credentials and Qualifications Committee report.

- 2.7.5.4. Assistance with Evaluation: The Medical Executive Committee, or any committee authorized by the MEC to review or evaluate applications for Staff membership or clinical privileges, or conduct ongoing review or evaluation of performance of those who currently hold Staff membership or clinical privileges, may as part of these duties:
 - 2.7.5.4.1. Obtain the assistance of an independent, qualified consultant or others to evaluate the subject individual;
 - 2.7.5.4.2. Consider the results of performance improvement or quality assessment activities of other hospitals or health care institutions with respect to the subject individual under evaluation;
 - 2.7.5.4.3. Request or require the subject individual under evaluation to submit to interviews with such consultants who may be retained per this Section 2.7.5 to assist in the review or evaluation process;
 - 2.7.5.4.4. Subject to Federal or State regulations, request that specific patient records or categories of records of patients treated by the subject individual under evaluation be submitted for review, subject to appropriate protection of patient confidentiality; and,

⁷⁵ MS.06.01.03; MS.06.01.05

2.7.5.4.5. Require detailed statements, data and information concerning matters that may impact the qualifications, professional competence, or conduct of the subject individual under evaluation, including information concerning pending legal or administrative proceedings or investigations, and peer review and quality management activities within other Broward Health Hospitals.

2.7.5.5. Board Action: Unless subject to the provisions of the fair hearing and appeal provisions in Art. VI of these Bylaws, the Board shall duly consider the recommendation of the MEC and act on the application at its next regular meeting following receipt of the recommendation from the MEC.⁷⁶ The action of the Board shall be taken within 30 days after receiving a recommendation from the applicable Medical Executive Committee. The Board's determination must be consistent with the criteria established by these Bylaws and applicable State and Federal law and it shall make specific findings as to the applicant's satisfaction of the requirements as set forth in these Bylaws.⁷⁷

2.7.5.5.1. If the Board adopts the recommendation of the Medical Executive Committee, it shall become the final action of the Hospital, unless the hearing provisions of these Bylaws apply.

2.7.5.5.2. If the Board does not adopt the recommendation of the Medical Executive Committee, the Board may either refer the matter back to the Medical Executive Committee with instructions for further review and recommendation and a time frame for responding to the Board, or the Board may decline to adopt the recommendation or modify the recommendation if it determines that the recommendation is not supported by the criteria for appointment or reappointment or the grant of the specific privileges requested pursuant to the Bylaws and provides the MEC in writing the specific grounds for such determination. If the matter is referred back to the Medical Executive Committee, the Medical Executive Committee shall reconsider the matter and shall forward its

⁷⁶ 42 C.F.R. §482.12(a)(2); 42 C.F.R. §482.22(a)(2); MS.01.01.01; MS.06.01.03; MS.06.01.07

⁷⁷ MS.06.01.03; MS.06.01.05

recommendation to the Board. If the Board adopts the recommendation of the Medical Executive Committee, it shall become the final action of the Hospital. In no event shall the Board take action in connection with the appointment, reappointment or grant of privileges that is inconsistent with the criteria for same established by the Medical Staff pursuant to the Bylaws.

- 2.7.5.5.3. If there is an adverse Board action regarding an application, following a favorable recommendation by the MEC then the Secretary of the Board shall promptly send written notice to the applicant and the recommending MEC and such notice shall include the grounds for such adverse Board action.⁷⁸ Such notice shall contain the information prescribed in the Article VI of these Bylaws. In such case, the applicant shall be entitled to procedural rights provided in the Article VI of these Bylaws, and the adverse decision of the Board shall not become final until after the applicant has exercised or waived such rights.⁷⁹ At its next regular meeting, after all of the applicant's hearing and appeal rights under these Bylaws have been exhausted or waived, the Board shall take final action, which will include any obligation to report the final action to any applicable reporting or Licensing Board.⁸⁰
- 2.7.5.5.4. All final action of appointment shall include a delineation of clinical privileges, the assignment of a staff category and Department affiliation within each Hospital affiliation(s), and any applicable conditions placed on the appointment or clinical privileges. The applicant shall be so notified.
- 2.7.5.5.5. Subject to any applicable provisions of Article VI, notice of the Board's final decision shall be given in writing through the Secretary of the Board to the applicant within five (5) working days of the final decision. In the event a hearing and/or appeal were held, Article VI shall govern notice of the Board's final decision.

⁷⁸ §395.019 (6), F.S.

⁷⁹ 42 U.S.C. §11111

⁸⁰ 42 U.S.C. §11133

2.8. PROVISIONAL STATUS AND PROCTORING

The Medical Staff shall have a process to evaluate the privilege-specific competence of a Practitioner who does not have documented evidence of competently performing the requested privilege at the Hospital. This process may also be used when a question arises regarding a currently privileged practitioner's ability to provide safe, high quality patient care. This process of focused professional practice evaluation shall be a time-limited period during which the Medical Staff evaluates and determines the practitioner's professional performance. Focused professional practice evaluation may entail the use of one or more types of evaluation, including but not limited to chart review, monitoring of clinical practice patterns, simulation, clinical proctoring, external peer review, and discussion with other individuals involved in the care of each patient (e.g., consulting physicians, assistants at surgery, nursing or administrative personnel).⁸¹ Clinical proctoring is an objective evaluation of an individual's actual clinical competence by a monitor or proctor who represents the Medical Staff and is responsible to the Medical Staff. When an initial applicant seeks clinical privileges, or an individual with existing clinical privileges seeks new privileges, or when the Medical Staff requires the individual's actual clinical competence to be evaluated for any other reason, the individual may be proctored or observed while providing the services for which the privileges are requested. In most instances, proctors act as monitors to evaluate the technical and cognitive skills of another Practitioner and do not directly participate in patient care, have no physician/patient relationship with the patient being treated, do not receive a fee from the patient, represent the Medical Staff, and are responsible to the Medical Staff.⁸²

- 2.8.1. For initial appointment/initial clinical privileges: Initial appointments and initial granting of clinical privileges shall be for a period of at least one year (12 months), and subject to extension for a total period not to exceed two years (24 months). A period of focused professional practice evaluation shall be implemented for all initially requested privileges.⁸³ Each individual subject to provisional status may be subject to focused professional practice evaluation by one or more appropriate member(s) of the Medical Staff as approved by the Chairperson of the Department to which the individual is affiliated. The provisional status individual shall be subject to focused professional practice evaluation for the number and type of cases, procedures, or treatments specified by the clinical Department as appropriate to the patient care and services provided by Department members. The care under evaluation shall be relevant to the privileges granted. The purpose of the evaluation is to determine the individual's eligibility for advancement from provisional status and for

⁸¹ MS.08.01.01

⁸² AMA Board of Commissioners Report 30-A-94

⁸³ MS.08.01.01

exercising the clinical privileges provisionally granted. If a proctor is assigned, the proctor shall complete a proctoring report with comments on the individual's performance. Each proctoring report will be evaluated when the case is completed in order to be aware of any undesirable trend or pattern that may be developing. At the end of the provisional period the individual must qualify for and be advanced to a non-provisional status, or be extended on provisional status for an additional period not to exceed twelve (12) months. Advancement shall be based upon a favorable recommendation of the individual's Department Chairperson based on the Chairperson's review of the proctoring reports, chart reviews, peer review, and any other results of focused professional practice evaluation and a favorable recommendation of the Credentials and Qualifications Committee and Medical Executive Committee, and reported to the Board for consideration. No one may be on provisional status for a total period longer than twenty-four (24) months. Unless excused for good cause by the Medical Executive Committee, and the Board, an individual's failure to complete the required number of cases needed to complete focused professional practice evaluation shall be deemed a voluntary relinquishment of membership and clinical privileges; such individual shall not be entitled to the hearing and appeal rights under these Bylaws. Failure to advance to a non-provisional category of membership due to performance issues shall entitle the individual to the hearing and appeal rights under these Bylaws.

- 2.8.2. For individuals with existing privileges who are requesting new privileges: A period of focused professional practice evaluation shall be implemented for all initially requested privileges.⁸⁴ Medical Staff members or other individuals with existing clinical privileges who are requesting new privileges may be subject to focused professional practice evaluation by one or more appropriate member(s) of the Medical Staff as approved by the Chairperson of the Department to which the individual is affiliated. In the event new privileges are requested for which there are no other Medical Staff members or other individuals with existing clinical privileges and competence to proctor and evaluate someone in the new area of practice, the Credentials and Qualifications Committee, and the Medical Executive Committee shall have the option to specify other means of review to determine competence, including but not limited to reports of completion of an accredited training program, evaluations from competent instructors, external peer review, and/or evidence of proctoring at another hospital. If a proctor is assigned, the proctor shall complete a proctoring report with comments on the individual's performance. Each proctoring report will be evaluated when the case is completed in order to be aware of any undesirable trend or pattern that may be developing. The

⁸⁴ MS.08.01.01

individual's Department Chairperson shall review the proctoring reports, chart reviews, peer review, and any other results of focused professional practice evaluation and provide a report to the Credentials and Qualifications Committee and the Medical Executive Committee.

2.9. PREVIOUSLY DENIED OR TERMINATED APPLICANTS

Notwithstanding any other provisions in these Bylaws, if an application is tendered by an applicant who has been previously denied membership and/or clinical privileges, or who has had membership and/or clinical privileges terminated due to lack of sufficient qualifications required to maintain membership or clinical privileges, or whose prior application was deemed incomplete and withdrawn, and it appears that the application is based on substantially the same information as when previously denied, terminated, or deemed withdrawn, then the application shall be deemed unacceptable for reconsideration by the Credentials and Qualifications Committee and returned to the applicant.

If an application is tendered by an applicant who has been previously denied membership and/or clinical privileges, or who has had membership and/or clinical privileges terminated due to circumstances that have permanently disqualified the applicant for membership, as has been so designated by prior action of the Board of Commissioners, then the application shall be returned to the applicant as unacceptable for processing. No application shall be processed, and no right of hearing or appeal shall be available in connection with the return of such application pursuant to this section.

2.10. EFFECT OF REMOVAL FROM OFFICE OR CONTRACT TERMINATION ON MEDICAL STAFF MEMBERSHIP OR CLINICAL PRIVILEGES

In the event a Practitioner who is employed by or has contracted with Broward Health is subject to removal through the termination or expiration of employment or of the contract, full effect shall be given to any specific provisions in the contract regarding the consequence that such termination or expiration of the contract has on the Medical Staff membership and clinical privileges of the Practitioner. In the event of such termination, the Practitioner shall have no rights to an appeal or hearing unless provided by contract. In the event a Practitioner was a member in good standing prior to entering into an employment or contract relationship with Broward Health and such contract does not address or otherwise impact the Practitioner's medical staff membership or privileges in the event of termination or expiration of the contract by its terms, then such membership and/or privileges shall not be terminated or otherwise surrendered upon the termination of the employment or contractual relationship. The underlying grounds for termination of the contract may themselves be cause for initiating adverse action under these Bylaws.

INDIVIDUALS PROVIDING PROFESSIONAL SERVICES BY CONTRACT OR EMPLOYMENT.

2.11. QUALIFICATIONS AND SELECTION

Practitioners providing clinical services pursuant to a contract or legal agreement or through Hospital-based and/or Community Health Services-based employment shall be subject to the same procedures as all other applicants for membership or privileges and shall be subject to the same obligations of Staff membership or clinical privileges, as outlined in these Bylaws.⁸⁵

2.12. LEAVE OF ABSENCE

A Medical Staff member or Allied Health Professional (AHP) may request a voluntary leave of absence from the Staff by submitting a written notice to the Chief Executive Officer and Chief of Staff. This request will be submitted to all Broward Health Hospitals in which the Medical Staff member or Allied Health Professional holds membership and privileges. The request must state the beginning date and ending date for the period of leave desired, which may not exceed one year, and include the reasons for the request. Upon written request, one (1) additional year of leave of absence may be granted if recommended by the Medical Executive Committee and approved by the Board. The Medical Executive Committee shall review and recommend leave of absence requests to the Board of Commissioners, but in extenuating circumstances such as military leave, the Chief Executive Officer and Chief of Staff shall have the authority to approve a leave of absence and their actions shall be reported to the Medical Executive Committee and Board of Commissioners. During the period of leave, the Practitioner or AHP shall not exercise clinical privileges at the Hospital, and membership prerogatives and responsibilities shall be in abeyance. When the reasons for the leave of absence indicate that the leave is for medical or military purposes, the request shall be granted at the discretion of the Medical Executive Committee based on their evaluation of the abilities of the Medical Staff to fulfill the patient care needs that may be created in the Hospital by the absence of the Medical Staff member or AHP requesting the leave. A leave of absence shall be granted for Medical Staff members or AHPs in good standing, provided all incomplete medical records and Medical Staff and Hospital matters have been concluded. Exceptions shall be allowed only in the event that a Medical Staff member or AHP has a physical or psychological condition that prevents him/her from completing records or concluding other Medical Staff or Hospital matters. A leave of absence may be granted for the following reasons:

2.12.1. MEDICAL LEAVE OF ABSENCE

A Medical Staff member or AHP may request and be granted a leave of absence for the purpose of obtaining treatment for a medical or psychological condition, disability, or impairment. If an individual is unable to request a medical leave of absence because of a physical or

⁸⁵ MS.03.01.01; MS.03.01.03

psychological condition, the Chief of Staff or Chairperson of the individual's Department may submit the written notice on his/her behalf. A certified letter will be sent to the individual informing him/her of this action. Reinstatement of membership status and/or clinical privileges may be subject to submission of appropriate evidence by the individual that he/she has the ability to resume the obligations of Medical Staff membership and/or perform the clinical privileges requested to be reinstated.

2.12.2. MILITARY LEAVE OF ABSENCE

A Medical Staff member or AHP may request and will be granted a leave of absence to fulfill military service obligations. In addition to a written request for leave, a military reservist shall submit a copy of deployment orders. Medical Staff members or AHPs who are on active military duty for more than one year will be afforded an automatic extension of their leave until their active duty is completed. Reinstatement of membership status and/or clinical privileges may be subject to certain monitoring and/or proctoring conditions as determined by the Medical Executive Committee, based on an evaluation of the nature of activities during the leave.

2.12.3. EDUCATIONAL LEAVE OF ABSENCE

A Medical Staff member or AHP may request and be granted a leave of absence to pursue additional education and training. Any additional clinical privileges that may be desired upon the successful conclusion of additional education and training must be requested in accordance with Article IV of these Bylaws

2.12.4. PERSONAL/FAMILY LEAVE OF ABSENCE

A Medical Staff member or AHP may request and be granted a leave of absence for a variety of personal reasons (e.g., to pursue a volunteer endeavor) or family reasons (e.g., maternity leave). Reinstatement of membership status and clinical privileges may be subject to certain monitoring and/or proctoring conditions as determined by the Medical Executive Committee.

2.12.5. TERMINATION OF LEAVE

In order to request reinstatement of Medical Staff membership and/or clinical privileges, the Medical Staff member or AHP on leave of absence shall submit a written notice to the Chief of Staff. The written request shall include an attestation that no changes have occurred in the status of any of the credentials listed in Article II, or if changes have occurred, a detailed description of the nature of the changes. The Staff

member or AHP shall submit a summary of relevant activities during the leave, which may include, but is not limited to the scope and nature of professional practice during the leave period and any professional training completed. If the leave of absence has extended past the Practitioner's or AHP's reappointment time, he/she will be required to submit an application for reappointment in accordance with Article II of these Bylaws, which shall include any applicable attestation, and the reinstatement shall be processed as a reappointment. The Chief of Staff will forward the request for reinstatement to the individual's Department Chairperson for a recommendation. The Department Chairperson shall forward his/her recommendation to the Credentials and Qualifications Committee. The Credentials and Qualifications Committee shall make a recommendation and forward it to the Medical Executive Committee and the MEC shall forward its recommendation to the Board for due consideration and final decision. In acting upon a request for reinstatement, the Board may approve reinstatement either to the same or a different staff category, and may approve full reinstatement of clinical privileges, or a limitation or modification of clinical privileges, or approve new clinical privileges in accordance with the procedures in Article IV. If the leave of absence has been greater than one year, then terms of an initial focused review may apply. An adverse decision regarding reinstatement of Staff membership or renewal of any clinical privileges held prior to the leave shall entitle the Practitioner to a fair hearing and appeal as provided in these Bylaws.

2.12.6. FAILURE TO REQUEST REINSTATEMENT

Failure, without good cause, to request reinstatement in writing shall be deemed a voluntary resignation from the Medical Staff and/or voluntary relinquishment of clinical privileges. A request for Medical Staff membership or clinical privileges subsequently received from a Medical Staff member or AHP deemed to have voluntarily resigned shall be submitted and processed in the manner specified for applications for initial appointment.

2.13. RESIGNATION

Resignations from the Medical Staff should be submitted in writing and should state the date the resignation is requested to become effective. Resignations shall be submitted to the Chief of Staff. Resignation of Medical Staff membership and/or clinical privileges may be granted for a Practitioner or AHP in good standing provided all incomplete medical records and Medical Staff and Hospital matters have been concluded. The Practitioner's or AHP's Department Chairperson shall be advised of the request for resignation. Upon acceptance of the resignation by the Board, the Practitioner or AHP will be notified in writing. When a resignation is accepted or clinical privileges are relinquished during the course of an investigation regarding improper conduct or incompetence, a report

shall be submitted to the state professional licensing board for reporting to the NPDB, as required by state and federal law.⁸⁶

2.14. ACTIONS INVOLVING AN IMPAIRED PRACTITIONER OR OTHER IMPAIRED INDIVIDUAL WITH CLINICAL PRIVILEGES

The Medical Staff, through its Medical Executive Committees and as approved by the UMSC, has adopted a Practitioner Health/Impaired Physician Policy that addresses the handling and response to a circumstance or condition of impairment or potential impairment of a Practitioner and the Medical Staff shall comply with its Impaired Physician policy in the investigation and response to such a circumstance of impairment or suspected impairment, as defined in the policy. The policy may be amended by UMSC, subject to the approval of the Board, and shall be uniform and applicable to all four Medical Staffs and hospitals.⁸⁷

2.14.1. EDUCATION

Medical Staff members and Allied Health Professionals, as appropriate, shall be educated about illness and impairment recognition issues specific to physicians and Allied Health Professionals, including education about warning signs.⁸⁸ Warning signs may include, but are not restricted to, perceived problems with judgment or speech, alcohol odor, emotional outbursts, behavior changes and mood swings, diminishment of motor skills, unexplained drowsiness or inattentiveness, progressive lack of attention to personal hygiene, or unexplained frequent illnesses.

2.14.2. TREATMENT/REHABILITATION/MONITORING AND/OR REINSTATEMENT GUIDELINES

If it is determined that the individual suffers from an impairment that could be reasonably accommodated through rehabilitation or medical/psychological treatment, the following criteria and processes shall apply with respect to recommendations for treatment, rehabilitation, monitoring, and/or reinstatement:

2.14.2.1. An individual with impairment shall not be reinstated until it is established, to the Medical Staff's satisfaction, that the individual has successfully completed a rehabilitation program in which the Medical Staff has confidence, or has received

⁸⁶ Health Care Quality Improvement Act; 42 U.S.C. §11135; 45 C.F.R. §60.9(a)(ii); §395.0191, F.S.; 59A-3.275, F.A.C.

⁸⁷ AMA Definition of Impairment; §456.076, F.S.; 42 C.F.R. §12114; Regional Administrative Policy RA-013-005

⁸⁸ MS.11.01.01

treatment for a medical or psychological impairment such that the condition is under sufficient control.

- 2.14.2.2. The Medical Staff is not required to extend membership or privileges to an individual with impairment, and may monitor, test, or order any appropriate requirements of the individual in order to consider or grant privileges or membership to the individual.
- 2.14.2.3. Upon sufficient proof that the individual who has been found to be suffering from impairment has completed a program or received treatment as described above, the Medical Staff, in its discretion, may consider the impaired individual for reinstatement of Medical Staff membership or clinical privileges.
- 2.14.2.4. In considering an impaired individual for reinstatement, the Hospital and Medical Staff leadership must consider patient care interests paramount.
- 2.14.2.5. The Medical Staff must first obtain a letter from the physician director of the rehabilitation program where the impaired individual was treated, or the physician directing the impaired individual's medical or psychological treatment. The impaired individual must authorize the release of this information consistent with state and federal law. The following information shall be requested in providing guidance to the physician director regarding the content of the letter:⁸⁹
 - 2.14.2.5.1. Whether the impaired individual is participating in the program or treatment;
 - 2.14.2.5.2. Whether the impaired individual is in compliance with all of the terms of the program or treatment plan;
 - 2.14.2.5.3. Whether the impaired individual attends AA/NA meetings regularly (if appropriate);
 - 2.14.2.5.4. To what extent the impaired individual's behavior and conduct are monitored;
 - 2.14.2.5.5. Whether, in the opinion of the treating physician, the impaired individual is rehabilitated or the medical/psychological impairment is under control;

⁸⁹ 42 C.F.R. §2.1; §456.059, F.S.

- 2.14.2.5.6. Whether an after-care program has been recommended to the impaired individual (if appropriate), and if so, a description of the after-care program; and,
- 2.14.2.5.7. Whether, in the opinion of the treating physician, the impaired individual is capable of resuming practice and providing continuous, competent care to patients.
- 2.14.2.6. The Medical Staff has the right to require opinion(s) from other physician consultants of its choice.
- 2.14.2.7. Assuming all of the information received indicates that the individual is sufficiently in recovery or rehabilitated or the medical/psychological condition is under control, the Medical Staff shall take the following additional precautions when restoring clinical privileges:
 - 2.14.2.7.1. The impaired individual must identify a physician or peer who is willing to assume responsibility for the care of his/her patients in the event of his/her inability or unavailability;
 - 2.14.2.7.2. The individual shall be required to sign a release for the Medical Staff to obtain periodic reports from the rehabilitation program, after-care program, or treating physician – for a period of time specified by the Medical Executive Committee – stating that the individual is continuing treatment or therapy, as appropriate, and that his/her ability to treat and care for patients in the Hospital is not impaired.
- 2.14.2.8. The individual must agree to submit to an alcohol or drug-screening test (if appropriate to the impairment) at the request of the Chief Executive Officer, the Chief of Staff, or the Chairperson of the individual's Medical Staff Department(s).
- 2.14.2.9. As a condition of reinstatement, the impaired individual's credentials shall be re-verified from the primary source and the verification documented, in accordance with the procedures in these Bylaws. Minimally, licensure, DEA, and professional liability insurance shall be verified. Additionally, the Hospital shall query the National Practitioner Data Bank, the OIG Sanction Report, and the GSA List. The Hospital may

also re-verify any other qualification or competence if there is reasonable belief that it may have been adversely affected by the circumstances related to the impairment.

2.14.2.10.If at any point during the process of investigation, treatment, rehabilitation, monitoring, and/or reinstatement, the individual refuses or fails to comply with these procedures, he/she may be subject to a summary suspension from the Medical Staff and afforded due process as defined in the provisions of the Medical Staff Bylaws, unless the individual's contract with Broward Health states otherwise, such as when automatic termination is the penalty stated in the contract.

2.14.2.11.If at any time during the diagnosis, treatment, rehabilitation, and/or monitoring phase of this process it is determined that the individual is unable to safely perform the privileges he/she has been granted, the matter shall be forwarded to the Medical Executive Committee for appropriate corrective action that includes strict adherence to any state or federally mandated reporting requirements.⁹⁰

2.14.2.12.All requests for information concerning the impaired individual shall be forwarded to the Regional Chief Executive Officer for response. Information concerning an individual seeking referral or referred for assistance shall be maintained with confidentiality, except as limited by law, ethical obligation, or when the safety of a patient is threatened.⁹¹

2.15. ACTIONS IN RESPONSE TO DISRUPTIVE CONDUCT

It is the policy of the Medical Staff to support a work environment of that supports teamwork, respect and courtesy in the treatment of all individuals involved in the delivery of health care, patients and their families. To that end, the Medical Staff, through its Medical Executive Committees and approved by Unified Medical Staff Committee, has adopted a policy addressing disruptive behavior and unprofessional conduct governing Medical Staff members and the Medical Staff shall comply with this policy in the investigation and response to a circumstance of disruptive conduct by a Practitioner.

ARTICLE III. CATEGORIES OF MEDICAL STAFF AND HONORARY RECOGNITION

3.1. CATEGORIES

⁹⁰ MS.11.01.01; §395.0191(6), F.S.

⁹¹ MS.11.01.01

The categories of Medical Staff membership shall include the following: Active-primary, Active Non-primary, Provisional, Courtesy, Consulting, Senior Active and Honorary. At the time of initial appointment and at each reappointment, the member's staff category shall be recommended by the Medical Executive Council and approved by the Board.⁹² All categories of membership must meet the general Medical Staff membership qualifications set forth in these Bylaws at the time of appointment, reappointment and as a condition of continued membership in good standing.

3.2. LIMITATIONS ON PREROGATIVES

The prerogatives of Medical Staff membership in these Bylaws are general in nature and may be limited or restricted by special conditions attached to a Practitioner's appointment or reappointment, by state or federal law or regulations, or other provisions of these Bylaws, the Rules and Regulations, or other policies, commitments, contracts or agreements of the Hospital.

3.3. ACTIVE STAFF

3.3.1. ACTIVE-PRIMARY MEDICAL STAFF

The Active-primary Staff category shall consist of those Medical Staff members who have satisfactorily completed their term as Provisional members, have the minimum number of 18 patient contacts at the time of reappointment and are regularly involved in and actively support the Medical Staff and Broward Health by contributing to efforts to fulfill Medical Staff functions. The Active Staff category shall be responsible for oversight of care, treatment and services provided by the Medical Staff, and members in the Active Staff category shall have the requisite skills for providing such oversight.⁹³ If all requirements for Active-primary staff are not met, the member may request Courtesy status provided he or she meets the criteria for that category of membership. Members who meet the Active Staff category requirements shall be Active-primary at the hospital they designate as their Primary Facility and shall have the right to vote.

3.3.2 ACTIVE NON-PRIMARY MEDICAL STAFF

The Active Non-Primary Medical staff shall consist of Medical Staff members who have satisfactorily completed their term as Provisional members, have a minimum number of 18 patient contacts at the time of reappointment, as determined for each hospital, and are regularly involved in Medical Staff functions as an Active-primary member at their primary facility. The Active Non-Primary Medical staff do not hold office or

⁹² 42 C.F.R. §482.22(c)(3)

⁹³ MS.06.01.03

need to attend meetings at their non-primary facility. The Active Non-Primary shall have the right to vote on matters related to rules & Regulations and Departmental issues, but not for election of officers. If all requirements for Active Non-Primary Medical staff are not met, the member may request Courtesy Status provided he or she meets the criteria for that category of membership.

3.3.3 SENIOR ACTIVE MEDICAL STAFF

The Senior Active Medical Staff shall consist of those Medical Staff members who have served at least fifteen calendar years on the staff of at least one of the hospitals of Broward Health and have reached the age of 55 or older; or have reached the age of 60, and have served ten calendar years. Members of the Senior Active Medical Staff shall have the minimum amount of patient contacts to maintain Active membership status and shall have the right to vote but shall have no assigned duties except at the request of the Chief of Staff and the concurrence of the member

3.3.4. COURTESY MEDICAL STAFF

The Courtesy Staff category shall consist of Medical Staff members who have less than the minimum patient contacts for Active-Primary or Active Non-Primary status and are not regularly involved in the Medical Staff functions. All members of the Courtesy Staff must first have satisfactorily completed appointment in the Provisional staff category with respect to the obligations of 2.12.1, as applicable and must have at least four patient contacts at the time of reappointment to maintain membership. Courtesy Medical staff members having more than the minimum number of patient contacts annually to qualify for Active Primary or Non-Primary Active shall, upon review of the Department, Credentials and Qualifications Committee and the Medical Council, be recommended for appointment to Active-Primary or Active Non-Primary staff. Members of the Courtesy staff must be actively associated with another local Hospital and provide documentation at the time of reappointment from that local Hospital that they are a member in good standing.

- 3.3.4.1. Members of the Courtesy Staff shall not be eligible to vote or hold office within the Medical Staff organization. A Courtesy Staff member may serve on committees of the Medical Staff or Hospital and may attend Medical Staff and Department meetings.

3.3.5. PROVISIONAL MEDICAL STAFF

The Provisional staff category shall consist of new Medical Staff members who have been approved by the appropriate Department, Credentials and

Qualifications Committee, Medical Executive Committee, and the Board of Commissioners, but have not yet qualified for Active-Primary, Active Non-Primary or Courtesy Staff appointment. Provisional staff members shall be permitted to admit patients and exercise such clinical privileges as provided within these Bylaws.

A member shall remain in the Provisional category for a minimum of one year before he or she is eligible to become an Active-Primary or Active Non-Primary staff member. At the end of one year, he or she may be elevated to another category or the Provisional status may be extended by the Medical Council for an additional one-year period for further evaluation. A Provisional member must have a minimum number of patient contacts, at the hospital where he or she desires to attain Active-Primary or Active Non-Primary status, and meet all staff membership requirements before he or she may become an Active-Primary or Active Non-Primary member. Any Provisional member who does not meet the requirements for Active-Primary or Active Non-Primary membership after the initial or additional year as a Provisional member may request appointment to the Courtesy staff.

At the end of each one-year period described above, the performance of each provisional member shall be evaluated by the Department in which he has privileges and the Department Chairperson shall communicate the results of the evaluation to the Credentials and Qualifications Committee. If the Provisional member has demonstrated clinical competence and is otherwise qualified for continued staff membership the member shall be elevated to the appropriate category, upon recommendation of the Credentials and Qualifications Committee, MEC and the Board. Any Provisional member who has not qualified for elevation to the Active-Primary or Active Non-Primary or Courtesy staff by the end of the second year will be dropped from the medical Staff for failure to meet the requirements of medical staff membership and such decision shall not be deemed a termination or restriction on privileges or medical staff membership so as to require reporting of same to the NPDB or any applicable licensing board. If a Provisional member attains medical staff membership at more than one hospital of Broward Health, he or she must designate the hospital at which he or she is primarily involved as his or her primary facility. Provisional members must pay annual dues and satisfy the meeting attendance requirements only at their primary facility.

3.3.6. CONSULTING MEDICAL STAFF

The Consulting staff category shall consist of members who meet the following criteria:

- 3.3.6.1 Members who are trained and practice in a limited, but highly subspecialized area of medicine or surgery.

- 3.3.6.2 Licensed psychologists who are consulted to provide health care to patients and family members in the hospital within the scope of their practice in the form of consultative evaluations and therapy, per their Delineation of Privileges;
- 3.3.6.3 Because of their very limited, specialized activity in the Hospital, members of the Consulting staff do not have admitting privileges and do not vote.

The requirements of Section 2.1.7.2 regarding Board Certification may be met for an applicant to the Consulting Category who meets the following criteria: (i) completion of an ASTS (American Society of Transplant Surgeons) approved fellowship program; (ii) certification by the Board of Surgery in the country of surgical training; (iii) minimum of two years experience in transplant surgery for which privileges are being requested; (iv) recognized as a Fellow by the American College of Surgeons; and (v) cannot meet the Board Certification requirements due to circumstances regarding his or her training and has not otherwise been denied or failed to achieve Board Certification for any reason. Such waiver must be recommended by the Medical Executive Committee, upon consideration of the recommendation of its Credentials & Qualifications Committee.

3.3.7. HONORARY MEDICAL STAFF

The Honorary staff category will be by invitation only of the MEC. Nomination may be made by majority vote of the sponsoring Department or by the MEC. The Honorary Medical Staff shall consist of either 1): Practitioners who have retired from Active-Primary or Active Non-Primary practice at a Broward Health hospital, have contributed to the hospital and its Medical Staff by their exemplary service and who continue to maintain the appropriate professional and ethical standards; or 2): Practitioners who are of outstanding reputation and not necessarily residing in the community. Honorary staff members may not admit patients or exercise clinical privileges and, as a consequence, are not required to maintain a current medical license or be subject to any credentialing process and may not vote.

3.3.8 AFFILIATE MEDICAL STAFF

The affiliate staff shall consist of medical staff members who desire to maintain a professional and collegiate relationship with one or more of the Broward Health Hospitals and their respective Medical Staffs and who fall within one or more of the following categories:

1. Have academic appointments with medical, dental or osteopathic schools and use the hospital for teaching students and residents in

accordance with teaching programs with Broward Health (“Academic Affiliate”); or

2. Are community based physicians whose patients are primarily admitted for in-hospital care through hospitalist arrangements or as otherwise directed by the patient’s health care coverage (“Non-Clinical Affiliate”); or
3. Are community based physicians who refer their patients for hospital services, such as diagnostic or out-patient services and surgeries, (“Non-Clinical Affiliate”); or
4. Are physicians with designated limited privileges to perform a specialized service pursuant to a contractual arrangement with Broward Health such as neurologic telemedicine consulting or preparation of discharge summaries (“Specialized Services Affiliate Service”)’ or
5. Are physicians who have been a member of the Medical Staff in good standing whose in-patient practice has diminished in volume but desire to maintain a non-clinical professional association with the Medical Staff and the Hospital (“Non-Clinical Affiliate”)

Members of the affiliate medical staff who exercise limited privileges in the Academic or Specialized Services category do not have hospital admitting privileges, may not write or otherwise provide orders for treatment and care of patients in the in-patient hospital setting, and may not write in the physician progress notes. All Non-Clinical Affiliate medical staff members do not render clinical care in the hospital and shall not apply for or receive any Delineation of Privileges. Affiliated members may not vote, nor may they participate in the election of medical staff officers. The application process shall be in the same manner as required for all other applicants and any privileges shall be expressly delineated in accordance with the parameters of this category.

As the Non-Clinical Affiliate medical staff members do not have privileges to practice in the hospital they are not subject to OPPE in connection with any in hospital privileges. With respect to the Academic Affiliate and Specialized Services Affiliate medical staff members, OPPE and such other quality review and monitoring shall be correspondingly limited to the specialized privileges granted and the exercise of those delineated privileges.

3.3.9 ASSOCIATE MEDICAL STAFF

The Associate Medical Staff shall consist of Medical Staff members who are either independent contractors or employees and who provide medical care at the District’s community health clinics and ambulatory

care centers. Members of the Associate Medical Staff do not have hospital admitting privileges, and do not render care within the hospital setting in connection with their Associate Medical Staff standing. Associate Members may not vote, nor may they participate in the election of Medical Staff Officers.

Notwithstanding any provision in these Bylaws to the contrary, and in the absence of any explicit language in the Associate Member's contract to the contrary, the termination of the Member's contract for the provision of services to a center, or the termination of the Member's employment with the District, shall result in the automatic termination of the Associate Member's Associate Medical Staff membership and clinical privileges. The Associate Member shall have no right to a hearing, review or appeal of such action, except as set forth in the Broward Health's Community Health Services Rules and Regulations.

As the Associate Medical Staff exercises privileges in connection with their Associate Medical Staff membership and standing in the community health clinics and ambulatory care centers, OPPE and such applicable quality and professional review functions are carried out by the Section and by those processes account to the Medical Executive Committee and the Governing Body.

3.4. CHANGE IN STAFF CATEGORY

Pursuant to a request by the Medical Staff member, upon a recommendation by the Credentials and Qualifications Committee, or pursuant to its own action, the Medical Executive Committee may recommend a change in medical staff category of a member consistent with the requirements of the Bylaws. The Board shall approve any change in category, prior to such change taking affect.

3.5. INTERNS, EXTERNS, RESIDENTS, AND FELLOWS

The terms, "interns," "externs," "residents," and "fellows," (hereinafter referred to collectively as "house staff") as used in these Bylaws, refer to Practitioners who are currently enrolled in a graduate medical education program approved by the applicable Medical Executive Committee and the Board, and who, as part of their educational program, will provide health care services at Broward Health. House staff shall not be considered Practitioner/Licensed Independent Practitioners, shall not be eligible for clinical privileges or Medical Staff membership, and shall not be entitled to any of the rights, privileges, or to the hearing or appeal rights under these Bylaws. House staff shall be credentialed by the sponsoring medical school or training program in accordance with provisions in a written affiliation agreement between the Hospital and the school or program; credentialing information shall be made available to Broward Health upon request and as needed by the Medical Staff in making any training assignments and in the

performance of their agreed to participation and supervisory function. The school or program shall provide a written description of the role, responsibilities, and patient care activities of participants in the training program.⁹⁴ In compliance with federal laws, it shall not be necessary to submit a query to the National Practitioner Data Bank prior to permitting a house staff Practitioner to provide services at this Hospital. House staff Practitioners may render patient care services at the Hospital only pursuant to and limited by the following:

- 3.5.1. House staff Practitioners who have completed the basic level of training for licensure shall be licensed in this State and shall be limited by applicable provisions of the professional licensure requirements of this State;
- 3.5.2. The protocols or policies established by the Medical Executive Committee, in conjunction with the sponsoring medical school or training program, and as approved by the Board, regarding the scope of a house staff Practitioner's authority (e.g., authority and circumstances under which they may write patient care orders and make entries in the patient record, subject to supervision and countersignature by a supervising LIP), mechanisms for the direction and supervision of a house staff Practitioner (e.g., mechanisms for the supervising LIP and the school's program director to make decisions about each house staff Practitioner's progressive involvement and independence in specific patient care activities), and other conditions imposed upon a house staff Practitioner by Broward Health or the Medical Staff.⁹⁵
- 3.5.3. While functioning in the Hospital, house staff Practitioners shall abide by all provisions of the Medical Staff Bylaws, Rules and Regulations, and Hospital and Medical Staff approved policies and procedures, and shall be subject to limitation or termination of their ability to function at the Hospital at any time in the discretion of the Chief Executive Officer or the Chief of Staff. House staff Practitioners may perform only those services set forth in the training protocols developed by the applicable training program to the extent that such services do not exceed or conflict with the Rules and Regulations of the Medical Staff or Hospital policies, and to the extent approved by the Board. A house staff Practitioner shall be responsible and accountable at all times to a member of the Medical Staff, and shall be under the supervision and direction of a member of the Medical Staff. House staff Practitioners may be invited or required to attend meetings of the Medical Staff, Medical Staff Departments, Specialties, or committees, but shall have no voting rights.

⁹⁴ MS.04.01.01

⁹⁵ MS.04.01.01

- 3.5.4. The Graduate Medical Education Committee shall be responsible for overseeing house staff Practitioners and shall communicate to the Medical Executive Committee and the Board about the patient care provided by, and the related educational and supervisory needs of, the participants in the professional graduate education programs, including demonstrated compliance with any residency review committee citations as applicable to the program.⁹⁶
- 3.5.5. As defined in Section 3.8 above, house staff Practitioners are distinguished from Practitioners who, although currently enrolled in a graduate medical education program, provide patient care services independently at the Hospital (e.g., “moonlighting” or locum tenens coverage) and not as part of their educational program. Such Practitioners who provide independent services must meet the qualifications for Medical Staff membership and clinical privileges as provided in these Bylaws and shall be subject to the credentialing procedures specified in these Bylaws in the same manner as a Practitioner seeking appointment to the Medical Staff.

3.6. ALLIED HEALTH PROFESSIONALS

The term, “Allied Health Professional” (AHP) refers to individuals, other than those defined as a Practitioner, who provide direct patient care services in the Hospital under a defined degree of supervision, exercising judgment within the areas of documented professional competence and consistent with applicable law. Categories of AHPs eligible for clinical privileges shall be approved by the Board and shall be credentialed through the same processes as a Medical Staff member, as described in Article II, and shall be granted clinical privileges as either a dependent or independent healthcare professional as defined by State law and in these Bylaws. Although AHPs are credentialed as provided in these Bylaws in Article II, only independent AHPs are eligible for Medical Staff membership. They may provide patient care services only to the extent of the clinical privileges that have been granted. The Board has determined the following categories of individuals eligible for clinical privileges as an AHP: physician assistant (PA), anesthesiology assistant (AA), advanced registered nurse practitioner (ARNP), certified registered nurse anesthetist (CRNA), certified nurse midwife (CNM).

Other categories of dependent healthcare professionals who are not hospital employees but who provide patient care services in support of, or under the direction of a Medical Staff member shall have their qualifications and ongoing competence verified and maintained through a process administered by the Hospital. Categories of dependent healthcare professionals subject to such Hospital processes, policies and procedures shall include, without limitation, Health Care Industry Representatives (HCIRs), operating room nurses and

⁹⁶ MS.04.01.01

technicians, perfusionists, surgical first assistants, clinical assistants, autotransfusionists, orthotists/prosthetists, registered and practical nurses, dental technicians, lactation consultants, doulas, and medical assistants. Hospital policies and procedures shall govern the actions and patient care services provided by dependent healthcare professionals. These categories of dependent healthcare professionals are not considered Allied Health Practitioners. Although a Medical Staff member may provide employment, sponsorship, and supervision of a non-hospital-employed dependent healthcare professional through the terms of a sponsorship agreement, which shall impose binding responsibilities upon the Medical Staff member, these Bylaws shall not apply to such dependent healthcare professionals. Dependent healthcare professionals are listed here only to distinguish them from AHPs.⁹⁷

A Medical Staff member who fails to fulfill the responsibilities as outlined in the Rules and Regulations and/or in a sponsorship agreement for the supervision of an AHP or a dependent healthcare professional shall be subject to appropriate actions provided by these Bylaws.

3.6.1. REQUIREMENTS FOR DEPENDENT ALLIED HEALTH PROFESSIONALS

As permitted by state law, AHPs shall be responsible and accountable at all times to a member of the Medical Staff, and shall be under the supervision and direction of a member of the Medical Staff. The terms of the accountability of the dependent AHP to the Medical Staff member and the terms for supervision of the dependent AHP by a Medical Staff member shall be documented in a sponsorship agreement between the AHP and the sponsoring Medical Staff member. In addition to a complete application, as defined in these Bylaws, a sponsorship agreement shall be on file at the Hospital. The sponsorship agreement and requests for clinical privileges shall contain all of the following information:

- 3.6.1.1. Name of the sponsoring Medical Staff member(s);
- 3.6.1.2. Evidence of compliance with state licensing standards (e.g. physician assistants must register his or her sponsor with the State of Florida);⁹⁸
- 3.6.1.3. Completed sponsoring Medical Staff member's evaluation;
- 3.6.1.4. Requested clinical privileges shall specify the degree of supervision required for the performance of each clinical

⁹⁷ CMS Conditions of Participation 482.12(e); HR.01.02.01; HR.01.02.05; HR.01.02.07; HR.01.06.01; HR.01.07.01

⁹⁸ §456, F.S.

privilege, and shall be signed by the sponsoring Medical Staff member(s);

3.6.1.5. Signed agreement by the sponsoring Medical Staff member(s) to provide required supervision and accept responsibility for the patient care services provided by the AHP; and,

3.6.1.6. Requests for initial sponsorship and additional sponsorship must be recommended by the Department Chairperson of the requested sponsor, the Credentials and Qualifications Committee, and the Medical Executive Committee, and approved by the Board of Commissioners.

3.9.2. PREROGATIVES OF ALLIED HEALTH PROFESSIONALS

AHPs shall not be eligible to vote, or hold office within the Medical Staff organization. An AHP may attend Medical Staff or Department/Section meetings if invited.

3.9.3. OBLIGATIONS OF ALLIED HEALTH PROFESSIONALS:

Each AHP shall discharge the basic obligations of Staff members as required in these Bylaws, and abide by these Bylaws, the Rules and Regulations, and all other rules, policies and procedures, guidelines, and other requirements of the Medical Staff and the Hospital, as applicable to his/her activities in association with the Hospital.

3.9.4. CONDITIONS OF APPOINTMENT

Appointment of Dependent AHPs must be approved by the Board and may be terminated by the Board or the Chief Executive Officer. Adverse actions or recommendations affecting AHP privileges shall not be covered by the provisions of the Fair Hearing Plan. However, the affected AHP shall have the right to request to be heard before the MEC with an opportunity to rebut the basis for termination. Before the appearance, the AHP shall be informed of the general nature and circumstances giving rise to the action, and the AHP may present information relevant thereto. Minutes of the appearance and consideration shall be made. MEC shall, after conclusion of the investigation, submit a written decision to the AHP.

The AHP shall have a right to appeal to the Board any decision rendered by the MEC. Any request for appeal shall be required to be made within fifteen (15) days after the date of the receipt of the MEC decision. The written request shall be delivered to the Chief Executive Officer of Broward Health, with a copy to the applicable Chief of Staff, and shall include a brief statement of the reasons for the appeal. If

appellate review is not requested within such period, the AHP shall be deemed to have accepted the action involved which shall thereupon become final and effective immediately upon affirmation by the Board. If appellate review is requested the Board shall, within fifteen (15) days after the receipt of such an appeal notice, schedule and arrange for appellate review, which review shall be conducted by a panel of three Board members selected by the Chair. The Board shall give the AHP notice of the time, place and date of the appellate review, which shall not be less than fifteen (15) days nor more than sixty (60) days from the date of the request for the appellate review. The appeal shall be in writing only, and the AHP's written statement must be submitted at least five (5) days before the review. The MEC may also submit a statement. New evidence and oral testimony will not be permitted. The Board shall uphold the decision of the MEC absent showing by the AHP that the decision was erroneous, arbitrary or otherwise not in compliance with the applicable criteria for appointment or termination by a majority vote of those Board members present during the appellate proceedings. A record of the appellate proceedings shall be maintained.

AHP privileges shall automatically terminate upon revocation, termination or resignation of the privileges of the AHP's supervising physician member, unless another qualified physician indicates his/her willingness to supervise the AHP and complies with all requirements hereunder for undertaking such supervision. In the event that an AHP's supervising physician member's privileges are significantly reduced or restricted, the AHP's privileges shall be reviewed and modified by the Board upon recommendation of the MEC. Such actions shall not be covered by the provisions of the Fair Hearing Plan.

ARTICLE IV. CLINICAL PRIVILEGES

4.1. EXERCISE OF PRIVILEGES

Every Practitioner or Allied Health Professional granted clinical privilege pursuant to these ByLaws shall be entitled to exercise only those clinical privileges specifically granted to him/her by the Board.⁹⁹ The privileges must be Hospital-specific, within the scope of the individual's license to practice in the State of Florida or any certificate or other legal credential authorizing practice in this State and consistent with any restrictions thereon, within the scope of the individual's current competence, and subject to the Rules and Regulations of the Department or Section. Clinical privileges may be granted, continued, modified, or terminated by the Board upon the recommendation of the Medical Staff, for reasons directly related to quality of patient care and other provisions of the Bylaws, and following the procedures outlined in these Bylaws. Each Practitioner

⁹⁹ MS.03.01.01; MS.03.01.03; MS.06.01.07

must obtain consultation with another Practitioner who possesses appropriate clinical privileges in any case when the clinical needs of the patient exceed the clinical privileges of the Practitioner(s) currently attending the patient.¹⁰⁰ Additionally, consultation must be obtained when required by these Bylaws, the Medical Staff and Department/Section Rules and Regulations, and other policies of the Medical Staff and the Hospital, which set forth criteria to determine which clinical procedures or treatments, or medical, surgical, or psychiatric conditions require consultation.¹⁰¹

4.2. DELINEATION OF PRIVILEGES

4.2.1. APPLICATION

Clinical privileges may be granted only upon formal request pursuant to forms provided by the Medical Staff office. Every application for appointment and reappointment must contain a request for the specific clinical privileges desired by the applicant. Only those clinical privileges supported by evidence of competence and proof that the applicant meets the criteria for each privilege will be processed through the application process. Pursuant to Section 2.7.3, the responsibility for providing all necessary information to process a request for clinical privileges shall be the applicant's.

4.2.2. ADMITTING PRIVILEGES

Only Medical Staff members with clinical privileges or qualified Practitioners granted temporary privileges may be granted admitting privileges. The privilege to admit shall be delineated, and is not automatic.¹⁰²

4.2.3. ADDITIONS TO CLINICAL PRIVILEGES

A request by an individual with clinical privileges for additional clinical privileges or modifications in clinical privileges may be made at any time, but such requests must be supported by documentation of training and/or experience supportive of the request. In processing such a request, the National Practitioner Data Bank and the State Licensing Board will be queried, and the response used by the Medical Staff and the Board in considering the request.¹⁰³ The following documentation shall be considered with any requests for an increase in clinical privileges and new clinical privileges:

¹⁰⁰ MS.03.01.03

¹⁰¹ MS.03.01.03

¹⁰² MS.03.01.01; MS.06.01.07; MS.06.01.03

¹⁰³ 42 U.S.C. §11135; C.F.R. §60.10

- 4.2.3.1. Training, continuing education, and experience related to the new clinical privileges requested shall be verified;¹⁰⁴
- 4.2.3.2. Evidence of current competence related to the new clinical privileges requested shall be verified;
- 4.2.3.3. Information provided by peers of the applicant shall be included in deliberations when increasing privileges;
- 4.2.3.4. Information regarding organization(s) that currently privilege the applicant in order to obtain evidence of the practitioner's professional practice review, volumes, and outcomes from those organization(s); and¹⁰⁵
- 4.2.3.5. When revising clinical privileges the applicant shall be required to respond to queries regarding whether there have been any:
 - 4.2.3.5.1. Previously successful or currently pending disciplinary actions, or voluntary relinquishment, of licensure or registration;¹⁰⁶
 - 4.2.3.5.2. Voluntary or involuntary suspension, reduction in privileges or termination of privileges or membership;¹⁰⁷ and/or,
 - 4.2.3.5.3. Involvement in any liability actions, including any final judgments or settlements.¹⁰⁸

4.2.4. BASIS FOR PRIVILEGE DETERMINATION

There shall be criteria for granting, renewing or revising clinical privileges that are directly related to the quality of healthcare and pertain to the evidence of current competence and ability to perform the privileges requested.¹⁰⁹ Applications and requests for clinical privileges shall be evaluated on the basis of the applicant's education, training, current competence, the ability to perform the clinical privileges requested, professional references and peer recommendations that include written information about the applicant's medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, professionalism, information from the

¹⁰⁴ MS.12.01.01

¹⁰⁵ MS.06.01.05

¹⁰⁶ MS.06.01.05

¹⁰⁷ MS.06.01.05

¹⁰⁸ MS.06.01.05

¹⁰⁹ MS.06.01.05

applicant's current or past facility affiliations regarding membership status and current competence, professional liability experience and insurance coverage, and other relevant information, including an evaluation by the Chairperson of the Clinical Department in which the privileges have been sought.¹¹⁰ The criteria for granting clinical privileges shall also include whether the hospital has the ability to provide adequate facilities and supportive services.¹¹¹

The basis for privilege determinations for continuation of privileges shall include, in addition to the above listed information, the results of ongoing professional practice evaluation,¹¹² as provided for in Article II of these Bylaws. Additionally, all individuals with delineated clinical privileges are required to participate in continuing education as related to their privileges,¹¹³ and the applicant's participation in continuing education shall be considered when renewing or revising such privileges.¹¹⁴ Before clinical privileges are granted, renewed, or revised by the Board of Commissioners, the Medical Staff shall evaluate each applicant with regard to the following information and make a recommendation based on the following information:¹¹⁵

- 4.2.4.1. For applicants in fields performing operative and other procedures, the types of operative procedures performed as the surgeon of records, the handling of complicated deliveries, or the skill demonstrated in performing invasive procedures, including information about appropriateness and outcomes of the procedures;
- 4.2.4.2. For applicants in non-surgical fields, the types and outcomes of medical conditions managed by the applicant as the responsible physician;
- 4.2.4.3. The applicant's clinical judgment and technical skills;
- 4.2.4.4. Any evidence of unusual patterns of, or an excessive number of, professional liability actions resulting in a final judgment against the applicant;
- 4.2.4.5. Information from quality assessment and performance improvement, including but not limited to review of operative and other procedures, use of blood and blood products, use of medications, review of medical records, utilization

¹¹⁰ MS.06.01.05

¹¹¹ MS.06.01.01; MS.06.01.07

¹¹² MS.05.01.03; MS.08.01.03

¹¹³ MS.12.01.01

¹¹⁴ MS.12.01.01

¹¹⁵ MS.06.01.03; MS.06.01.07; MS.08.01.03

management/medical necessity review, risk management data, and patient safety data;

- 4.2.4.6. Relevant practitioner-specific data that are compared to aggregate data;
- 4.2.4.7. Morbidity and mortality data;
- 4.2.4.8. Practitioner's use of consultants; and,
- 4.2.4.9. Practitioner's performance relative to approved standards of practice, patient care protocols, and evidence-based clinical practice guidelines, including but not limited to compliance with CMS' core measures protocols and AHCA publicly reported patient safety indicators and inpatient quality indicators.

The information used in the ongoing professional practice evaluation may be acquired through periodic chart review, direct observation, monitoring of diagnostic and treatment techniques, and discussion with other individuals involved in the care of each patient including the consulting physicians, assistants at surgery, nursing and administrative personnel.¹¹⁶ Additionally, in considering any request to grant, continue, modify, or increase clinical privileges, the MEC or its Credentials and Qualifications Committee, or the Board may, in its discretion, obtain assistance of an independent, qualified consultant with their evaluation, as provided for in Article II of these Bylaws. In addition, those practitioners seeking new, additional or renewed clinical privileges must meet all criteria for Medical Staff membership as described in these Bylaws, including a query of the National Practitioner Data Bank.¹¹⁷

4.2.5. DELINEATION

Requests for clinical privileges shall be processed pursuant to the procedures outlined in Article II of these Bylaws and Governing Body shall be duly obligated to take into consideration the evaluation and conclusions of the Medical Staff as to an applicants qualifications for privileges and requests for reappointment or the grant of additional or curtailment of existing privileges and to adopt such conclusions and recommendations of the Medical Staff absent a determination is not supported by the criteria for appointment and reappointment or the grant of the specific privileges, with such determination made in writing. Clinical privileges shall be delineated on an individual basis. In evaluating an applicant who requests renewal or revision of clinical

¹¹⁶ MS.08.01.03

¹¹⁷ MS.06.01.05

privileges, the evaluation shall include ensuring that the applicant does not practice outside the scope of privileges granted, and information about the applicant's change in scope of practice shall be reflected when updated privilege delineation is made, and only approved privileges that are within the scope of practice shall be permitted.¹¹⁸ The delineation of an individual's privileges shall include the limitations, if any, on the individual's privileges to admit or treat patients or direct the course of treatment of the patients who have been admitted.¹¹⁹

4.2.6. LOCUM TENENS PRIVILEGES

Clinical privileges may be granted to a Practitioner qualified as described in Article II, Section 2.1, who plans to practice within the Hospital on an intermittent or substitute basis. A locum tenens Practitioner may not vote, hold office, or serve on any committees of the Medical Staff unless requested by the Medical Executive Committee. The locum tenens Practitioner shall be credentialed as described in Article II, and if qualified may be granted requested delineated clinical privileges for a period limited to the time during which the Practitioner is serving as a substitute for a Medical Staff member or providing services on such intermittent basis per contract but in no case shall the term of privileges be greater than two years from the date the clinical privileges were approved. The locum tenens Practitioner may be eligible for temporary privileges in accordance with Section 4.3 of these Bylaws. The locum tenens Practitioner shall be subject to the Medical Staff Bylaws, Rules and Regulations, and policies.

4.2.7. NEW/TRANSPECIALTY PRIVILEGES

Prior to accepting request of a privilege, the resources necessary to support the privilege shall be determined to be currently available, or available within a specified time frame in accordance with Art. II, Section 2.2.1.¹²⁰ Any request for clinical privileges that have not previously been performed at the Hospital or that overlaps more than one Department shall initially be reviewed by the Credentials and Qualifications Committee. The Credentials and Qualifications Committee shall facilitate the establishment of hospital-wide credentialing criteria for the new or transpecialty procedure, with the input of all appropriate Departments, with a mechanism designed to ensure that the same level of quality of patient care is provided by all individuals with such clinical privilege.¹²¹ In establishing the criteria for such clinical privileges, the Credentials and Qualifications Committee may establish an ad-hoc committee with representation from all appropriate Departments or the committee

¹¹⁸ MS.06.01.07; MS.08.01.03

¹¹⁹ MS.06.01.07; MS.08.01.03

¹²⁰ MS.06.01.01

¹²¹ LD.01.05.01

members may undertake the process themselves. Information may be requested from one or more Practitioners or Departments, or from outside sources such as professional literature, certifying authorities or specialty associations. The recommendation of the Credentials and Qualifications Committee shall be forwarded to the Medical Executive Committee for its review and such consideration will include whether the new procedure or service is appropriate to the Hospital.

4.2.8. CLOSING/DISCONTINUING A SERVICE OR ENTERING AN EXCLUSIVE CONTRACT

As part of the process for ongoing evaluation and planning of patient care services and upon prior consultation with the applicable MEC(s), the Board of Commissioners may determine that a particular patient care service shall be closed or discontinued, or that a particular service shall be provided through an exclusive contract. In the event that the Board determines a patient care service should be closed, discontinued, or shall be provided only through an exclusive contract, the Board of Commissioners shall retract the clinical privileges associated with the provision of those services and notify the affected Practitioners and AHPs of the clinical privileges that have been retracted.¹²² Clinical privileges shall be retracted due to changes in the services provided by the Hospital, and retraction of clinical privileges shall not be considered an adverse action, therefore, there shall be no right to hearing and appeal in association with decisions to change the services offered by the Hospital and such retraction shall not be reported to the NPDB.

4.2.9. TELEMEDICINE PRIVILEGES

Practitioners who wish to provide telemedicine services, as defined in these Bylaws, in prescribing, rendering a diagnosis, or otherwise providing clinical treatment to a Hospital patient, without clinical supervision or direction from a Medical Staff member, shall be required to apply for and be granted clinical privileges for these services as provided in these Bylaws and shall be required to meet all Medicare Conditions of Participation, and Florida law and Administrative Code.¹²³ The Medical Staff, subject to Board approval, shall define in the Rules and Regulations or Medical Staff policy which clinical services are appropriately delivered through a telemedicine medium, according to commonly accepted quality standards.¹²⁴ Consideration of appropriate utilization of telemedicine equipment by the telemedicine practitioner shall be encompassed in clinical privileging decisions.¹²⁵

¹²² MS.06.01.07

¹²³ MS.01.01.01

¹²⁴ MS.01.01.01 – MS.01.01.03

¹²⁵ MS.01.01.01 – MS.02.01.01; 42 C.F.R. §482.22; F.A.C. 64B8-9.014

4.2.10. USE OF ANCILLARY SERVICES BY NON-PRIVILEGED PRACTITIONERS

A Practitioner who is not a Medical Staff member and who has not been granted clinical privileges may order outpatient ancillary services and the Hospital may accept and execute orders for outpatient ancillary services from Practitioners who are not members of the Medical Staff and who have not been granted any clinical privileges at the Hospital only if all the following conditions are met:

- 4.2.10.1. The Practitioner shall provide proof of current licensure within the State of Florida, which shall be verified by the Hospital;¹²⁶
- 4.2.10.2. If medications are being ordered, the Practitioner shall provide proof of current, unrestricted DEA registration;
- 4.2.10.3. The Practitioner shall be limited to ordering only those tests or services that are within the scope of his/her license to order, as established by State law. The orders shall be confined to those for outpatient laboratory, non-invasive procedures including radiology, rehabilitation services (including physical therapy, occupational therapy, and speech therapy), diagnostic cardiopulmonary or electrodiagnostic testing, or medications;
- 4.2.10.4. The order can be executed within the standards of the applicable disciplines under which the order is to be performed without the presence or supervision of the ordering professional;
- 4.2.10.5. The ordering professional does not hold himself or herself to be associated or affiliated with the Hospital or its Medical Staff;
- 4.2.10.6. The Practitioner's ordering practices shall be subject to the supervision of the medical director of the Hospital department performing the test or service, or the Chief of Staff. The Practitioner's ordering practices shall be subject to a review for medical appropriateness and necessity. Orders that lack evidence of medical appropriateness or necessity shall not be performed and the Practitioner shall be notified immediately to be given the opportunity to clarify/justify the order; and,
- 4.2.10.7. All diagnostic tests that require an interpretation by a Practitioner with a delineated clinical privilege to do so shall be

¹²⁶ 42 C.F.R. §482.11(c)

subject to interpretation by a member of the Medical Staff with such privileges and the interpretation shall be provided to the non-privileged Practitioner.¹²⁷

4.2.11. LIMITED LICENSURE PRACTITIONERS

Requests for clinical privileges from limited licensure Practitioners (e.g., Licensed Independent Practitioners who are not physicians) shall be processed in the manner and based on the same conditions as for any applicant for clinical privileges. Patients admitted by a limited licensure Practitioner with admitting privileges shall be under the care of a physician member of the Medical Staff with respect to any medical or psychiatric problem that is present on admission or develops during hospitalization that is outside the scope of practice of the admitting Practitioner.¹²⁸ The limited licensure Practitioner shall be responsible for securing the services of such physician member of the Medical Staff prior to the admission of the patient and shall supply the name of the physician to the Hospital. The limited licensure Practitioner shall be responsible for performing the part of the history and physical examination related to the care he/she will provide:

- 4.2.11.1. Dentists are responsible for the part of their patients' history and physical examination and updates that relates to dentistry.¹²⁹
- 4.2.11.2. Podiatrists shall arrange for the admission of a patient by a physician member of the Medical Staff and prescribe within the scope of their privileges. A physician member of the Medical Staff shall be responsible for the general history and physical and the care of any medical problems which arise during hospitalization or surgical procedure and for the total health status of the patient. Podiatrists shall be responsible for the podiatric care of the patient, including the podiatric history and extremity physical examination, as well as, all appropriate elements of the patient's record. Podiatrists may write orders within the scope of their privileges and consistent with these Bylaws and the Rules and Regulations.
- 4.2.11.3. A maxillofacial or oral surgeon who can document through his/her credentials appropriate capability, by education, training, and experience, may be granted privileges to admit patients, perform the history and physical on the patient, and

¹²⁷ §395.0195, F.S.

¹²⁸ 42 C.F.R. §482.12(c)(4); MS.03.01.03

¹²⁹ MS.03.01.01

otherwise perform the responsibilities hereinafter set forth for both the dental and general healthcare of the patient.

4.2.11.4. Other Licensed Independent Practitioners who are permitted to provide patient care services independently may perform all or part of the medical history and physical examination and updates, if granted such privileges. The findings, conclusions, and assessment of risk shall be confirmed or endorsed by a qualified physician prior to major high-risk (as defined by the Medical Staff in the Rules and Regulations or policy) diagnostic, or therapeutic interventions.¹³⁰

4.2.11.5. In addition, as permitted by state law and by the Medical Staff as specified in policy, individuals who are not Licensed Independent Practitioners may perform part or all of a patient's medical history and physical examination and updates under the supervision of, or through appropriate delegation by, a specific qualified physician. The specific qualified physician shall retain accountability for the patient's medical history and physical examination.¹³¹

4.3. TEMPORARY PRIVILEGES

Temporary clinical privileges shall be granted only to individuals defined as Practitioners in these Bylaws, to fulfill an important patient care need that cannot be otherwise met by the existing members of the Medical Staff. Therefore, temporary privileges shall be granted only rarely. In granting temporary privileges, special requirements may be imposed in order to monitor and assess the quality of care rendered by the Practitioner exercising such privileges. A Practitioner shall not be entitled to the procedural rights of fair hearing or appeal afforded by these Bylaws because of his/her inability to obtain temporary privileges or because of any termination of temporary privileges.

4.3.1. QUALIFICATIONS

Prior to temporary privileges being granted, an applicant for such privileges must demonstrate that he/she possesses a current license within the State of Florida, a current and unrestricted DEA registration and State of Florida registration, evidence of ability to perform the temporary privileges requested, current competence related to the temporary privileges requested, and documentation of professional liability insurance coverage as required by the Board,¹³² except as specified in this Article. Qualifications for temporary privileges shall be

¹³⁰ MS.03.01.01

¹³¹ MS.03.01.01; MS.06.01.07; MS.08.01.03; 42 C.F.R. §482.22(c)(5)

¹³² MS.06.01.03

verified from a primary source or designated agent of the primary source,¹³³ and documented. The National Practitioner Data Bank shall be queried prior to the granting of temporary privileges. Additionally, the Hospital shall verify the applicant's status as an Ineligible Person. For this purpose, the applicant shall provide his/her Medicare NPI, and the Hospital shall check the OIG Sanction Report, the GSA List, and the State Exclusion List. If the applicant is excluded from such participation, temporary privileges shall not be granted; any exclusion subsequent to having been granted temporary privileges shall result in immediate termination of such privileges. When applying for temporary privileges, each applicant shall agree to be bound by the Medical Staff Bylaws, Rules and Regulations, departmental rules and regulations, and applicable Hospital policies.

4.3.2. CONDITIONS AND AUTHORITY FOR GRANTING TEMPORARY PRIVILEGES

Temporary privileges may be granted by the Chief Executive Officer upon receiving a recommendation from both the appropriate Department Chairperson and the Chief of Staff under the conditions noted below.¹³⁴ Individuals practicing based on temporary privileges shall be acting under the supervision of the Chairperson of the Department to which he/she is assigned. All temporary privileges shall be time-limited, as specified for the type of temporary privileges listed below.¹³⁵ Temporary privileges shall automatically terminate at the end of the specific period for which they were granted, without the Hearing and Appeal rights set forth in these Bylaws. Temporary privileges shall be specifically delineated, and may include the privilege to admit patients.¹³⁶ A request for temporary privileges shall be made in writing, on forms approved for that purpose by Broward Health.

4.3.2.1. Early Privileges: After approval by the Credentials and Qualifications Committee, upon recommendation of the appropriate Department Chairperson and the Chief of Staff, the Chief Executive Officer shall have the authority to grant temporary privileges to a physician whose membership and privileges are awaiting review and recommendation by the Medical Executive Committee and approval by the Board of Commissioners. Such privileges shall be limited to 31 days and may be renewed under unusual circumstances to a maximum of 120 days. Applicants who meet any of the following conditions will not be considered for early privileges:

¹³³ MS.06.01.03

¹³⁴ MS.06.01.03

¹³⁵ MS.06.01.03

¹³⁶ MS.06.01.07; MS.08.01.03

- 4.3.2.1.1. Current or previously successful disciplinary actions to licensure or registration;
 - 4.3.2.1.2. Adverse membership actions at another hospital;
 - 4.3.2.1.3. Adverse actions against privileges at another hospital; or,
 - 4.3.2.1.4. Final judgments adverse to the applicant in a professional liability action.
- 4.3.2.2. Care of Specific Patient(s): Temporary privileges may be granted on a case-by-case basis when an important patient care need justifies the authorization to practice, for a limited period of time as defined herein, while full credentials information is verified and approved. After receipt of a written request for temporary privileges, a Practitioner qualified as described in Article IV, Section 4.3.1 may be granted temporary privileges if the Practitioner has a specific skill not possessed by a privileged Practitioner, and the specific skill is needed by a specific patient, authorization may be granted to provide care for that specific patient. Temporary privileges granted under this condition shall not exceed the length of stay of the specific patient or one hundred and twenty (120) consecutive days, whichever is less.¹³⁷ A Practitioner may be granted temporary privileges under this condition for no more than two patients in a twelve-month period. After a Practitioner has been granted temporary privileges under this condition for the care of a second patient within twelve months, he/she shall be invited to apply for Medical Staff membership.
- 4.3.2.3. Disaster Response and Recovery:¹³⁸ Potential disaster situations shall be described in the Disaster/Emergency Preparedness Plan of Broward Health. The grant of any temporary disaster privileges in furtherance of said Plan shall be made jointly by the Chief of Staff and CEO, if they are available to confer. In the event both the Chief of Staff and CEO are not available, either one may grant such temporary disaster privileges.

ARTICLE V. CORRECTIVE ACTIONS

5.1. CRITERIA FOR INITIATION

¹³⁷ MS.06.01.03

¹³⁸ MS.06.01.03

Any person may provide information in writing to the Medical Staff about the conduct, performance, or competence of its members or other individuals with clinical privileges. When reliable information, including the results of quality assessment or performance improvement activities, indicates that an individual may have exhibited acts, demeanor, conduct or professional performance reasonably likely to be (1) detrimental to patient safety or to the delivery of quality of patient care within the Hospital, (2) unethical, (3) disruptive or harassing, (as defined in these Bylaws and in Medical Staff approved policies)¹³⁹ (4) contrary to the Medical Staff Bylaws or Rules and Regulations, or (5) below applicable professional standards, the Chief of Staff; appropriate Department Chairperson; and Chief Executive Officer shall review the complaint or referral and make any further inquiry to confirm the concern or question raised is credible. A determination will then be made as to whether to refer the matter to the Medical Executive Committee or such other appropriate peer review committee or otherwise to deal with the matter in accordance with the relevant Medical Staff policy. If it is determined to direct the matter to the Medical Executive Committee or other appropriate professional review committee, a written request for investigation shall be prepared, making specific reference to the performance information, activity, or conduct that gave rise to the request. The investigation shall be conducted pursuant to these Bylaws.¹⁴⁰

5.2. SUMMARY SUSPENSION OR RESTRICTION

Whenever there are reasonable grounds to believe that the conduct, activities, or inaction of a Medical Staff member poses a threat or significant impairment to the life, well-being, health, or safety of any patient, employee, or other person present at Broward Health and that the failure to take prompt action may result in imminent danger to the life, well-being, health, or safety of any such person, the Chief of Staff, the Chairperson of any department with respect to physicians in that department in conjunction with the Medical Executive Committee, or the hospital CEO, after conferring with the Chief of Staff or if he or she is unavailable, the Vice Chief of Staff, shall each have the authority to summarily suspend or restrict all or any portion of his or her clinical privileges. Such suspension shall not indicate the validity of the charges, but shall remain in force, without appeal, during the course of the investigation. Unless otherwise stated, such suspension or restriction shall become effective immediately upon imposition. In addition, the affected individual shall be provided with a written notice of the action within one day of imposition, with a copy to the CEO and MEC. This initial notice shall include a summary of facts and issues as then presently known to the suspending party regarding the individual's conduct that led to the summary suspension or restriction, and shall not substitute for the notice required in Article VI. Where appropriate and as applicable, the Chief of Staff or the Chairperson of the Practitioner's Department shall arrange for

¹³⁹ §456.063, F.S.

¹⁴⁰ MS.01.01.01

alternative medical coverage of a suspended Practitioner's patients in the Hospital, for coverage of patient care subject to a restriction, and alternative on-call coverage. The wishes of the patient shall be considered in the selection of an alternative Practitioner. When the individual being suspended or restricted is an Allied Health Professional, the sponsoring physician shall be responsible for arranging alternative coverage for the care normally provided by the suspended individual.

Within seventy-two (72) hours after such summary suspension, or as soon as reasonably practicable but in no event later than seven (7) days after such summary suspension, a meeting of the MEC shall be convened to review and consider the action taken. The MEC may recommend modification, ratification, continuation with further investigation or termination of the summary suspension. If the summary suspension is terminated or modified such that the practitioner's privileges are not materially restricted, the matter shall be closed and no further action shall be required.¹⁴¹

If the summary suspension is continued for purposes of further investigation the MEC shall reconvene within fourteen (14) days of the original imposition of the summary suspension and shall modify, ratify or terminate the summary suspension. If at that time the summary suspension is terminated or modified such that the Practitioner's privileges are not materially restricted, the matter shall be closed and no further action shall be required.

Upon ratification of the summary suspension or modification which restricts the practitioner's clinical privileges as delineated in Section 6.3.1, the Practitioner shall be entitled to the procedural rights provided in the Art. VI. The terms of the summary suspension shall remain in effect pending a final decision and the Board will be notified.

5.3. INFORMAL INVESTIGATION PROCESS

As an alternative to a formal corrective action, any professional review body, as defined herein, shall have the power to conduct an informal investigation of a Medical Staff member. Such collegial interventions on the part of Medical Staff leaders in addressing the conduct or performance of an individual shall not constitute corrective action, shall not afford the individual subject to such efforts to the right to a Hearing and Appeal, and shall not require reporting to the state licensure board or the NPDB, except as otherwise provided in these Bylaws. Alternatives to corrective action may include:

- 5.3.1. Informal discussions or formal meetings regarding the concerns raised about conduct or performance, including the actions outlined in Section 2.19 that may be taken to address disruptive conduct;

¹⁴¹ Health Care Quality Improvement Act.

- 5.3.2. Written letters of guidance, reprimand, or warning regarding the concerns about conduct or performance;
- 5.3.3. Notification that future conduct or performance shall be closely monitored and notification of expectations for improvement;
- 5.3.4. Suggestions or requirements that the individual seek continuing education, consultations, or other assistance in improving performance;
- 5.3.5. Warnings regarding the potential consequences of failure to improve conduct or performance; and/or,
- 5.3.6. Requirements to seek assistance for impairment, as provided in these Bylaws.¹⁴²

All such actions taken under this section shall be documented and made part of the member's credentialing file.

5.4. INVESTIGATION PROCESS

Investigation may be initiated in response to the circumstances arising in a single case, or to investigate a pattern or trend in performance. The Medical Executive Committee, the CEO or the Board may request an investigation. The Quality/Peer Review Committee may conduct such an investigation, or the Medical Executive Committee may assign the task to a Medical Staff officer, Department, Section, ad hoc committee, or other organizational component. If assigned to an ad hoc committee, the committee shall consist of (1) no more than three physicians from the initiating hospital who are not in direct economic competition with the affected member; (2) a Vice Chairperson of the involved department at any Broward Health hospital that is not the initiating hospital; and (3) a representative of the same specialty, not in direct economic competition with the affected member if feasible. Qualified independent consultants may be utilized in the investigation process as provided in these Bylaws. The investigation must include an invitation to the affected practitioner to interview with the investigating body and may also include interviews of other individuals or groups deemed appropriate by the investigating body. If the investigation is conducted by a group or individual other than the Medical Executive Committee, that group or individual must forward a written report of the investigation to the Medical Executive Committee within thirty (30) days after the assignment to investigate has been made or as soon as thereafter practical. The Medical Executive Committee may at any time within its discretion, terminate the investigation process and proceed with action as provided below. The investigation procedures shall not constitute a formal peer review hearing and need not be conducted in accordance with the formal procedures for a fair hearing. The affected practitioner shall not be entitled to be represented by an

¹⁴² MS.11.01.01

attorney at any review, meeting, or interview occurring prior to the fair hearing procedures outlined in these Bylaws.¹⁴³ The investigation shall proceed:

- 5.4.1. As deemed necessary by the investigating body, include a review of the medical record for specific cases, a review of aggregate performance data, a review of comparative data when available, a review of any verbal or written reports regarding any specific incidents, conduct or behavior, or any other information relevant to the matter being investigated; and,
- 5.4.2. A report of the investigation will be issued by the investigating body, which shall include reason for actions and recommended action. If it is a summary action, the report will also include all grounds supporting the need for immediate action, the specific Bylaw or rule violation not met, procedural steps to date, summary of affected practitioner's position and a recommendation to the Medical Executive Committee. The Chief of Staff of the initiating hospital shall advise the affected practitioner of the time and place at which the report of the ad hoc committee shall be considered by the Medical Executive Committee at least ten (10) days prior thereto. The affected member shall be invited to attend this meeting, review the ad hoc committee report, to make any statement to the MEC and answer any question they may have of him or her; however, this appearance shall not constitute a hearing and shall be preliminary in nature.

5.5. ACTION ON INVESTIGATION REPORT

At the conclusion of an investigation, the Medical Executive Committee shall:

- 5.5.1. Determine that corrective action is not warranted and dismiss the matter;
- 5.5.2. Determine that corrective action is warranted, and use one of the alternatives to corrective action, as described in Section 5.8 of these Bylaws; or,
- 5.5.3. Determine that corrective action is warranted, and recommend an adverse action, which shall entitle the individual subject to such action to the procedural rights described in Article VI.

5.6. TEMPORARY SUSPENSION UNRELATED TO DIRECT PATIENT CARE

The membership and/or clinical privileges of a member may be temporarily suspended for the following:

5.6.1. CHRONIC DELINQUENCY IN COMPLETING MEDICAL RECORDS

¹⁴³ 42 U.S.C. §11133

5.6.1.1. Each Hospital maintains records on a monthly basis of those Practitioner's who have not timely completed a patient's medical record, including but not limited to timely completion of H&P's; post-operative notes and Discharge orders pursuant to these Bylaws, applicable Rules & Regulations, Medical Staff approved policies and applicable laws and regulations published to all affected Practitioners. A Practitioner is considered chronically delinquent if he or she has failed to make or complete patient medical records for six of the last 12 months.

5.6.1.2. When a Practitioner falls within this definition of chronic delinquency, the Medical Staff office will notify Practitioner in writing. The Notice shall be sent to the Practitioner's office address and, if provided by the Practitioner, by email copy, and shall give the Practitioner five business days to come to the Hospital and correct the deficiency by completion of all untimely (late) medical records. If extenuating circumstances prevent the Practitioner from correcting the deficiency within the five-day period, the Practitioner may submit a written request for an extension which much detail the reason(s) the extension is required. The Chief of Staff or his or her designee may grant a reasonable extension, not to exceed 30 days, in the event the Practitioner has established an extenuating circumstance. Extenuating circumstances are an illness or some other disability, if the Practitioner is out of town, or some other valid, similar reason that would prevent the Practitioner from coming to the Hospital and correcting the deficiency within the five days provided.

Failure by the Practitioner to correct the deficiency within the time provided will result in the automatic loss of privileges to admit, examine and/or treat new patients until the delinquent medical records have been completed and the Practitioner's compliance verified to the Medical Staff office by Medical Records. The Member shall be permitted to continue caring for his or her patients already admitted to the hospital until they are discharged.

5.6.2 REVOCATION OR SUSPENSION OF MEDICAL LICENSE

Action by the Department of Health, State Board of Medical Examiners, revoking or suspending a Practitioner's license shall result in the automatic suspension of all privileges at all Broward Health hospitals and the matter shall be referred to the MEC for a determination of the appropriate process for Investigation. In no event shall the Practitioner be entitled to reinstatement of his or her privileges until his license is reinstated.

5.6.3 FAILURE TO PAY DUES

If a member has failed to pay his or her dues on or before the due date, notice shall be given to the member and a reasonable period of time shall be specified in the Notice by which the member must remit all past due amounts. The Notice shall further provide that the member's failure to remit the delinquent dues will be deemed a voluntary resignation of his or her membership. In the event a member who has voluntarily resigned under this Section seeks in the future to apply for Medical Staff membership, in addition to all such qualifications and obligations set forth in these Bylaws for membership, the applicant must, as a condition precedent, remit his or her delinquent dues as of the date of his or her resignation.

EFFECT OF TERMINATION OR AUTOMATIC VOLUNTARY RESIGNATION

Automatic termination or voluntary resignation of privileges under this Section 5.6 does not entitle a Practitioner to a fair hearing or appellate review procedures provided in Article VI. Automatic suspension under 5.6.1 or 5.6.3 shall not be considered a reportable event for purposes of reporting to the NPDB.

ARTICLE VI. FAIR HEARING AND APPELLATE REVIEW PROCEDURES

6.1. OVERVIEW

Fair hearing and appellate procedures shall be used when professional review actions are being taken when it involves a Practitioner applying for Medical Staff membership, for an existing Medical Staff member, and for any other Practitioner applying for or holding clinical privileges. AHP's with clinical privileges who are not applying for Medical Staff membership and who are not Medical Staff members are afforded a streamlined appeal process as outlined in Section 3.9.4 but shall not be entitled to the rights afforded under the Fair Hearing Plan.

6.2. REMOVAL FROM EMERGENCY CALL PANEL

Removal from the emergency on-call panel is established on a departmental level at each Hospital and is not an automatic benefit or privilege of Staff membership. No hearing or appeal rights under these Bylaws are available for any action or recommendation affecting a Practitioner's emergency on-call panel obligation(s).

6.3. HEARING RIGHTS

6.3.1. ADVERSE RECOMMENDATIONS OR ACTIONS

Only Practitioners/Licensed Independent Practitioners who are subject to an adverse recommendation or action are entitled to a hearing under

this Article. The following recommendations or actions taken by the MEC or if taken by the Board in action contrary to the favorable recommendation made to it, shall be deemed adverse and give rise to the fair hearing procedures set forth in this Article:

- 6.3.1.1. Denial of initial staff appointment;
- 6.3.1.2. Denial of reappointment;
- 6.3.1.3. Suspension of staff membership for a period in excess of fourteen (14) days;
- 6.3.1.4. Revocation of staff membership;
- 6.3.1.5. Limitation of the right to admit patients other than limitations applicable to all individuals in a Staff category or a clinical specialty, or due to licensure limitations for a period in excess of fourteen (14) days;
- 6.3.1.6. Denial of requested clinical privileges;
- 6.3.1.7. Involuntary reduction in clinical privileges for a period in excess of fourteen (14) days;
- 6.3.1.8. Summary suspension or restriction of clinical privileges for a period in excess of fourteen (14) days, as defined in Article V, Section 5.2;
- 6.3.1.9. Revocation of clinical privileges; or,
- 6.3.1.10. Involuntary imposition of significant consultation requirements where the supervising Practitioner has the power to direct or transfer care from the Practitioner under review, excluding monitoring that does not materially limit the Practitioner's ability to exercise privileges, such as monitoring incidental to provisional status or the granting of new privileges.¹⁴⁴

6.3.2. NOTICE OF ADVERSE RECOMMENDATION OR ACTION

A Practitioner against whom an adverse recommendation or action has been taken pursuant to Section 6.3.1 shall be given written notice of such action within 15 days of said adverse recommendation or action, which shall provide a summary of the Practitioner's rights at the hearing and shall:¹⁴⁵

¹⁴⁴ D'Arrigo v. South Jersey Hospital System., No. CUM-L-519-01 (N.J. Super Ct. App. Div. Nov. 7, 2003)

¹⁴⁵ 42 U.S.C.S. §11112(b)(1)(A-C)

- 6.3.2.1. State the reasons for an adverse recommendation or action;
- 6.3.2.2. Advise the Practitioner of his/her right to a hearing pursuant to the provisions of the Medical Staff Bylaws and of this Fair Hearing Plan;
- 6.3.2.3. Advise the Practitioner that the Practitioner has thirty (30) days following receipt of the notice to submit a written request for a hearing to the Chief of Staff by hand delivery to the Medical Staff Office or by certified or overnight mail service;
- 6.3.2.4. State that failure to properly request a hearing within thirty (30) days shall constitute a waiver of rights to a hearing and to an appellate review of the matter, and the recommendation for adverse action will become final upon approval by the Board of Commissioners; and
- 6.3.2.5. State that upon receipt of his/her hearing request, the Practitioner will be notified of the date, time, and place of the hearing.

The Chief of Staff shall immediately notify the Chiefs of Staff of all other Broward Health hospitals at which the affected member is a member of the Medical Staff of the Medical Executive Committee's adverse recommendation.

6.3.3. REQUEST FOR HEARING

A Practitioner shall have thirty (30) days following his/her receipt of a notice pursuant to Section 6.3.2 to file a written request for a hearing. Such requests shall be delivered to the Chief of Staff at the Medical Staff Office by hand delivery, certified mail or overnight mail service.¹⁴⁶

6.3.4. FAILURE TO REQUEST A HEARING

A Practitioner who fails to request a hearing within the time and in the manner specified in Section 6.3.3 waives any right to such a hearing and to any appellate review to which he/she might otherwise have been entitled.

6.4. HEARING PROCEDURES NOTICE

Upon receipt of a timely request for a hearing, the Chief of Staff shall deliver such request to the party whose recommendation or action prompted the request

¹⁴⁶ 42 U.S.C.S. §11112(b)(1)(B)(i – ii)

for hearing. At least thirty (30) days prior to the hearing, the Practitioner shall be sent written notice providing the following information:

6.4.1. The place, time, and date, of the hearing, which date shall not be less than 30 days after but no greater than 90 days from the date of the written request for hearing, unless both parties agree otherwise;¹⁴⁷ a list of the witnesses (if any) expected to testify at the hearing on behalf of the body whose action gave rise to the hearing request;¹⁴⁸

6.4.2. That the Practitioner involved has the right:¹⁴⁹

6.4.2.1. To be present at the hearing;

6.4.2.2. To representation by an attorney or other person of the Practitioner's choice;

6.4.2.3. 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;

6.4.2.4. To call, examine, and cross-examine witnesses;

6.4.2.5. To present evidence determined to be relevant by the Chairperson of the hearing committee, regardless of its admissibility in a court of law; and,

6.4.2.6. To submit a written statement at the close of the hearing.

6.4.2.7 That the right to a hearing may be forfeited if the Practitioner fails, without good cause, to appear; and

6.4.2.8 That the Practitioner must provide a list of witnesses (if any) to testify at the hearing on Practitioner's behalf no later than fifteen (15) days prior to the hearing.

6.4.3. APPOINTMENT OF HEARING COMMITTEE

6.4.3.1. A hearing shall be conducted by a Hearing Committee Panel appointed by the Chair of the Hearing Committee.

6.4.3.2. Composition of Hearing Committee: The Hearing Committee shall be composed of the Secretary/Treasurer of the Medical Staff of each Hospital, and the Vice Chairman of each clinical

¹⁴⁷ 42 U.S.C.S. §11112(b)(2)(A)

¹⁴⁸ 42 U.S.C.S. §11112(b)(2)(B)

¹⁴⁹ 42 U.S.C.S. §11112(b)(3)(i – v)

Department of each District Hospital. The Chair shall be designated by the Unified Medical Staff Committee. The Chair of the Hearing Committee shall designate the members of each individual hearing Committee Panel.

The Chair shall select a Panel of not less than three (3) individuals from the Hearing Committee who are not in direct economic competition with the affected member and who have not previously participated in the adverse recommendation or action and the hearing will be conducted before the selected Panel. One of the members so appointed will be designated as the Panel Chairperson by the Chair of the Hearing Committee. Knowledge of the matter shall not preclude a member from serving. Every effort shall be made to have at least one committee member of the same medical subspecialty as the Practitioner.

- 6.4.3.3. Objections to Composition of Hearing Committee: Promptly, but no less than twenty (20) days prior to the hearing, the Practitioner shall be advised in writing of the names of the Hearing Committee Panel. The Practitioner shall have five (5) days from the date of the notice in which to object to any Panel members regarding potential bias, prejudice, or conflict of interest. The Chair of the Hearing Committee, in consultation with the applicable Chief of Staff, shall determine the merit of such contention and, if the contention is found to be valid, shall appoint a substitute to serve on the hearing committee. Failure of the Practitioner to so advise the chair of the Hearing Committee shall be deemed a waiver of any objection to the membership committee.¹⁵⁰

6.5. HEARING PROCEDURES

6.5.1. PERSONAL PRESENCE

The personal presence of the Practitioner who requested the hearing shall be required. A Practitioner who fails without good cause to appear and proceed at such hearing shall be deemed to have waived his/her rights in the same manner and with the same consequence as provided in Section 6.3.4.

6.5.2. PRESIDING OFFICER

The Chairperson of the hearing committee Panel shall be the presiding officer. The presiding officer shall act to maintain decorum and to assure

¹⁵⁰ Imperial v. Suburban Hospital Association, Inc., 37 F.3d 1026 (4th Cir. 1994).

that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence. He/she shall be entitled to determine the order of procedure during the hearing and shall make all rulings on matters of law, procedure, and the admissibility of evidence.

- 6.5.3 No later than fifteen days prior to the Hearing the Practitioner, or his representative, and a representative of the MEC or Board whose adverse recommendation or action is the subject of review, shall exchange a list of documents or other materials intended to be introduced at the hearing and any changes or additions to the witness list previously exchanged, including rebuttal witnesses. Upon written request, the party upon whom such request is made shall make available all documents or other materials so disclosed for inspection and copying, at least five (5) business days prior to the scheduled hearing or such other time as is mutually agreed upon. Except for good cause shown, the Hearing Committee Panel shall not permit either side to present documents, exhibits or witnesses not so disclosed, exchanged (if requested) or listed. The parties further agree that all such documents exchanged shall be maintained as confidential peer review documents and shall not be distributed or disclosed except in the connection with the hearing.

6.5.4. REPRESENTATION

The Practitioner who requested the hearing shall be entitled to be accompanied and represented at the hearing by an attorney or another person of his/her choice.¹⁵¹ The MEC or the Board, depending on whose recommendation or action promoted the hearing, may also be accompanied or represented by an attorney or another person of its choice

6.5.5 RIGHTS OF PARTIES

During a hearing, each of the parties shall have the right to:¹⁵²

- 6.5.5.1. Call and examine witnesses;
- 6.5.5.2. Introduce exhibits;
- 6.5.5.3. Cross-examine any witness on any matter relevant to the issues;
- 6.5.5.4. Impeach any witness;

¹⁵¹ 42 U.S.C.S. §11112(b)(3)(C)(i)

¹⁵² 42 U.S.C.S. §11112(b)(3)(C)(iii – v)

6.5.5.5 Rebut any evidence; and

6.5.6. PROCEDURE AND EVIDENCE

The hearing need not be conducted strictly according to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs shall be admitted, regardless of the admissibility of such evidence in a court of law. The concern of the hearing committee is with determining the truth of the matter, providing adequate safeguards for the rights of the parties and ultimate fairness to both parties. The committee shall also be entitled to consider all other information that can be considered, pursuant to these Bylaws, in connection with applications for appointment or reappointment to the Medical Staff and for clinical privileges. At the Chairperson's discretion, each party shall, prior to or during the hearing, be entitled to submit memoranda concerning any issue of law or fact, and such memoranda shall become part of the hearing record.

6.5.7. BURDEN OF PROOF

The body whose adverse recommendation or action is the subject of the hearing shall have the initial obligation to establish by credible evidence that their recommendation or action is reasonable and not in violation of these Bylaws. The Practitioner shall thereafter have the obligation to establish by credible evidence that the challenged recommendation or action is in violation of the Bylaws or that the challenged recommendation or action is arbitrary, unreasonable, or capricious.

6.5.8. RECORD OF HEARING

A record of the hearing shall be made by a certified court reporter at the expense of the Medical Staff. Either party may, at its own expense, request a copy of the transcript.

6.5.9. POSTPONEMENT

Request for postponement of a hearing shall be granted by the Chairperson to a date agreeable to the hearing committee only by stipulation between the parties or upon a showing of good cause.

6.5.10. PRESENCE OF HEARING COMMITTEE MEMBERS AND VOTE

All members of the Hearing Committee Panel must attend at least 75% of the hearing proceedings, in the event the hearing is convened for multiple sessions and the substantial entirety of the hearing if held in

one session. A Panel member shall be provided with a transcript of any proceeding for which he or she was absent and shall confirm on the record that he or she has read the transcript prior to deliberations.

6.5.11. RECESSES AND ADJOURNMENT

The hearing committee may recess the hearing and reconvene the hearing for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed. The hearing committee shall, at a time convenient to itself, conduct its deliberations outside the presence of the parties. Upon conclusion of its deliberations, the hearing shall be declared finally adjourned.

6.6. HEARING COMMITTEE REPORT AND FURTHER ACTION

6.6.1. HEARING COMMITTEE REPORT

Within fourteen (14) days after the final adjournment of the hearing, the hearing committee shall make a written report of its findings and recommendations in the matter, which may confirm, modify or reverse the original adverse recommendation, as decided by a majority of the hearing committee, and shall forward the same, together with the hearing record and all other documentation considered by it, to the Chief of Staff of the Initiating Hospital for distribution to the MEC and to the Chair of the Hearing Committee.

6.6.2. NOTICE AND EFFECT OF RESULT

6.6.2.1. Notice: The Chief of Staff shall promptly send a copy of the result and report to the Practitioner by overnight mail, hand delivery or certified mail with a copy mailed or hand delivered to the Chief Executive Officer, MEC and to the Board.

6.6.2.2. Effect of Favorable Result:

If the Hearing Committee Panel's recommendation is favorable to the Practitioner, the Chief of Staff shall promptly forward it, together with all supporting documentation, to the Board for its final action which shall be consistent with the recommendation absent a determination the recommendation is in violation of the Bylaws or is otherwise arbitrary or capricious, and such result shall become the final decision of the MEC and the matter shall be considered closed.

- 6.6.2.3. Effect of Adverse Result for Practitioner: If the result of the Hearing Committee Panel continues to be adverse to the Practitioner in any of the respects listed in Section 6.3.1, the notice required by this Section shall inform the Practitioner of his/her right to request an appellate review by the Board as provided in Section 6.7.1.

6.7. INITIATION AND PREREQUISITES OF APPELLATE REVIEW

6.7.1. REQUEST FOR APPELLATE REVIEW

A Practitioner shall have thirty (30) days following his/her receipt of a notice pursuant to Section 6.6.3.2 of these Bylaws to file a written request for an appellate review. Such request shall be delivered to the Chief Executive Officer either in person or by certified or registered mail and may include a request for a copy of the Hearing Committee report and record of the hearing committee proceedings

6.7.2. FAILURE TO REQUEST APPELLATE REVIEW

A Practitioner who fails to request an appellate review within the time and in the manner specified in Section 6.7.1 waives any right to such review. Such waiver shall constitute acceptance of the result, which shall become immediately effective. The matter shall be considered closed.

6.7.3. NOTICE OF TIME AND PLACE FOR APPELLATE REVIEW

Upon receipt of a timely request for appellate review, the Chief Executive Officer shall deliver such request to the Board. As soon as practicable, the Board shall schedule and arrange for an appellate review which shall not be less than 30 days or greater than 90 days from the date of notice to the Practitioner of the time, place and date of the review. The time for the appellate review may be extended or expedited by the appellate review body for good cause.

6.7.4. APPELLATE REVIEW BODY

The appellate review shall be conducted by an appellate review committee of at least three (3) members of the Board appointed by the Chairperson of the Board, and two non-voting (2) members, representing a member of the Medical Executive Committee appointed by the Chief of Staff of the hospital where the subject matter of the appeal initiated. No person shall serve on the appellate review committee if that person has served on the hearing committee in the same case or if that person is in direct economic competition with the Practitioner. One of the three members of the Board shall serve as

Chairperson and the convened appellate review committee shall elect the Vice-Chairperson.

6.8. APPELLATE REVIEW PROCEDURE

6.8.1. NATURE OF PROCEEDINGS

The proceedings by the review committee shall be in the nature of an appellate review based upon the record of the hearing before the hearing committee, that committee's report, and all subsequent results and actions thereon. The proceedings shall be restricted to reviewing whether the Medical Staff Bylaws were followed and whether substantial evidence to support the recommendation is documented. The appellate review committee shall also consider the written statements, if any, submitted pursuant to Section 6.8.2 and such other material as may be presented and accepted under Sections 6.8.4 and 6.8.5.

6.8.2. WRITTEN STATEMENTS

The Practitioner seeking the review and the MEC may submit a written statement detailing the findings of fact, conclusions and procedural matters with which the party agrees or disagrees, and the reasons for such agreement or disagreement. This written statement may cover any matters raised at any step in the hearing process, and legal counsel may assist in its preparation. The statement shall be submitted to the appellate review committee through the Chief Executive Officer at least three (3) days prior to the scheduled date of the appellate review, except if such time limit is waived by the appellate review committee.

6.8.3. PRESIDING OFFICER

The Chairperson of the appellate review committee shall be the presiding officer. He/She shall determine the order of procedure during the review, make all required rulings, and maintain decorum.

6.8.3.1. Objections to Composition of Appellate Review Committee:
The Practitioner may challenge any member of the appellate review committee for any cause, which would indicate bias, prejudice or conflict of interest. The Chairperson, or if challenged, the Vice-Chairperson shall decide the validity of such challenges. His/Her decision shall be final.

6.8.4. ORAL STATEMENT

The appellate review committee, in its sole discretion, may allow the parties or their representatives to appear and make oral statements in favor of their positions. Any party or representative so appearing may be

requested to answer questions asked him/her by any member of the appellate review committee.

6.8.5. CONSIDERATION OF NEW OR ADDITIONAL MATTERS

New or additional matters of evidence not addressed or presented during the original hearing or in the hearing report, may be introduced at the appellate review only at the discretion of the appellate review committee for such purposes as the appellate review committee deems appropriate, upon showing of the party seeking to introduce the new matter or evidence that the new or additional matter of evidence could not have been discovered in time for the initial hearing and is relevant to a material issue. The requesting party shall provide, through the Chief Executive Officer, a written, substantive description of the matter or evidence sought to be introduced to the appellate review committee and the other party at least three (3) days prior to the scheduled date of the review.

6.8.6. PRESENCE OF MEMBERS AND VOTE

A majority of the appellate review committee must be present throughout the review and deliberations. All members of the appellate review committee must attend at least 75% of the hearing proceedings, in the event the hearing is convened for multiple sessions and the substantial entirety of the hearing if held in one session. A committee member shall be provided with a transcript of any proceeding for which he or she was absent and shall confirm on the record that he or she has read the transcript prior to deliberations.

6.8.7. RECESSES AND ADJOURNMENT

The appellate review committee may recess the review proceedings and reconvene the review proceedings at predetermined time for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon the conclusion of oral statements, if allowed, the appellate review shall be closed. The appellate review committee shall thereupon, at a time convenient to itself, conduct its deliberations outside the presence of the parties. Upon the conclusion of those deliberations, the appellate review shall be declared finally adjourned.

6.8.8. ACTION TAKEN

The appellate review committee may, as decided by a majority vote of its members, affirm, modify or reverse the adverse result or action.

6.8.8.1. Appellate Review Committee Decision: The appellate review committee's decision is the final decision in the matter and will be set forth its decision in its final Report, which shall become effective when ratified by the Board.

6.9. FINAL DECISION OF THE BOARD

6.9.1. BOARD ACTION

Within thirty (30) days after the conclusion of the appellate review, the Board shall consider the final Report of the appellate review committee's decision in the matter and shall send written notice of the Board's action thereupon to the Practitioner, to the Chief of Staff, to the MEC, and to the Chief Executive Officer.

6.10. GENERAL PROVISIONS

6.10.1. NUMBER OF HEARINGS AND REVIEWS

Notwithstanding any other provision of the Medical Staff Bylaws, no Practitioner shall be entitled as a right to more than one evidentiary fair hearing as provided in Article VI and one appellate review thereof with respect to a specific adverse recommendation or action.

6.10.2. RELEASE

By requesting a hearing or appellate review under this Article, a Practitioner agrees to be bound by the provisions of Article XI in these Bylaws relating to immunity from liability in all matters relating thereto.

6.10.3. CONFIDENTIALITY

The investigations, proceedings and records conducted or created for carrying out the provisions of the Fair Hearing Plan or for conducting peer review activities under the Medical Staff Bylaws are to be treated as confidential, protected to the fullest extent allowed by State and Federal Law.¹⁵³

6.10.4. REPORTING REQUIREMENTS

6.10.4.1. EXTERNAL REPORTING

The Hospital shall comply with all applicable Federal and/or State law(s) and in accordance with hospital policy and

¹⁵³ §395.0193, F.S.

procedures with respect to its external reporting obligations with respect to the final decision taken by the Board.¹⁵⁴

6.10.4.2. INTERNAL REPORTING

The Chief Executive Officer shall be responsible for communicating adverse actions regarding Practitioners to each Broward Health facility. Upon receipt of such notification, the Medical Staff of such other Broward Health hospitals shall immediately terminate or restrict the affected member's membership and/or privileges, as applicable, to conform with the outcome of the investigation, hearing, or appeal process. Any such termination or restriction based upon a final adverse action at another Broward Health facility shall not entitle the affected practitioner to any additional hearing or appeal rights.

6.10.5 EFFECT OF APPROVAL

The Board, by approving these Bylaws, confirms the Fair Hearing and Appellate Review procedures set forth in this Article are the applicable and governing procedures for Broward Health.

ARTICLE VII. OFFICERS OF THE MEDICAL STAFF

7.1. ELECTED OFFICERS OF THE STAFF

7.1.1. IDENTIFICATION

- 7.1.1.1. Chief of Staff
- 7.1.1.2. Vice Chief of Staff
- 7.1.1.3. Secretary-Treasurer of the Staff
- 7.1.1.4. Immediate Past Chief of Staff

7.1.2. QUALIFICATIONS

- 7.1.2.1. Officers must be certified by the appropriate specialty board, or have affirmatively established comparable competence, must be Active-Primary members of the Medical Staff at the Hospital in which they are nominated, must be skilled in managing conflict resolutions, and must remain members in good standing at the time of nomination and election and must continuously maintain such status during their term of

¹⁵⁴ 42 U.S.C.S. §11133(a)

office.¹⁵⁵ Failure to maintain such status shall create an immediate vacancy in that particular office. In the event a candidate is not board certified at the time of his or her nomination, the nominating committee shall determine whether he or she has comparable competence.

7.1.2.2. Nominees may only be nominated, elected, and serve an officer of the staff at one Broward Health facility per term. A nominee may be an elected officer of the medical staff or an officer of a clinical department or section but may not hold a dual departmental and staff office during the same term.

7.1.2.3. The nominee for Chief of Staff must be an Active-Primary member of the Medical Staff who has consecutively served as a regular participant or a voting member of the Medical Executive Committee at the Hospital at which he/she is nominated for a period totaling at least six years, with the immediately preceding two years as a voting member immediately preceding his/her nomination.

7.1.2.4. No Practitioner, who is an Active-Primary member of the Medical Staff and is actively practicing in the Hospital, shall be ineligible for election to an officer position solely because of his/her professional discipline, specialty, or practice. Any determination of ineligibility due to conflict of interest shall be made by the Medical Executive Committee in accordance with Section 7.6.5.

7.2. TERM OF OFFICE AND ELIGIBILITY FOR RE-ELECTIONS

7.2.1. TERM OF OFFICE

Officers shall take office on the first day of the Medical Staff year, May 1, and shall serve a two-year term, or until a successor is elected or appointed. Staff Officers may serve a maximum of two consecutive terms. Each officer shall serve in office until the end of his/her term or until a successor is duly elected and ratified by the Board, absent a vacancy. At the end of the Chief of Staff's term, he or she shall automatically serve as the Immediate Past Chief of Staff.¹⁵⁶

7.3. ATTAINMENT OF OFFICE

7.3.1. NOMINATION

¹⁵⁵ MS.01.01.01

¹⁵⁶ MS.01.01.01

7.3.1.1. The Medical Staff Officers Nominating Committee shall offer nominees for Vice Chief of Staff and Secretary-Treasurer of Staff. With respect to the Chief of Staff, the Nominating Committee shall offer or otherwise confirm the nomination of the Chief of Staff in accordance with this section. The slate of nominees shall be presented for approval to the Medical Executive Committee of the applicable Hospital at its January meeting. With respect to the office of Chief of Staff, it is the practice of the Medical Staffs that the Vice-Chief is nominated to and assumes the office of Chief of Staff and the Nominating Committee shall follow that practice unless a contrary recommendation, with good cause grounds in support thereof, is made to the Medical Executive Committee and approved by majority vote of the Medical Executive Committee. In such event, the Nominating Committee shall offer a nominee for Chief of Staff. The Medical Executive Committee shall review and approve the nominees recommended by the Nominating Committee to determine if they meet the qualifications as set forth in these Bylaws and In the event any nominee is not approved, the Medical Executive Committee shall direct the Nominating Committee to propose another nominee at the February meeting. In the event any additional nominee recommended by the Nominating Committee for consideration at the February Medical Executive Meeting is not approved, in compliance with this section, the Medical Executive Committee shall select the remaining nominee(s) at the February meeting and the names of the nominees shall be posted in the applicable hospital on the Medical Staff bulleting board no later than one week after the February meeting.

Nominations may also be made by petition signed by at least ten percent of the members of the active staff, with a signed statement of willingness to serve by the nominee, submitted to the Chief of Staff no later than the last business day in February. At its March meeting or by special meeting if Medical Executive Committee's March meeting is held later than March 20, the Medical Executive Committee shall review and approve any nominee proposed by qualified petition and if approved, any additional nominee shall be posted at the applicable Hospital on the Medical Staff bulleting board no later than March 23 Thereafter nominations shall be closed. In determining whether a nominee should be approved and placed on the slate for vote, the Medical Executive Committee shall exercise broad discretion in determining qualifications for office and ability to effectively serve and carry out the responsibilities of the applicable office. All nominations shall remain confidential until approved by the Medical Executive Committee and it confirms the nominees consent to run for office.

7.3.2. ELECTION

7.3.2.1. Elections will be held in April by written ballot. Numbered ballots shall be mailed to each Active-Primary Staff member of the affected hospital by April 2 and must be returned to the

Medical Staff Office by April 16 to be considered. Voting shall be by secret written ballot, and every authenticated sealed ballot received timely shall be counted. Mailed ballots shall include an interior unmarked envelope for the return of the ballot and an outside return envelope with a handwritten signature of the voting Member, or other authentication process approved by the Chief of Staff. Prior to the votes being tallied, a voting member may confirm with the Medical Staff office that his or her return ballot has been received and in the event a returned ballot cannot be located, a voting member may hand-deliver a replacement ballot to the Medical Staff office at least one day prior to the actual tallying of the votes which shall be counted upon confirmation his or her original return ballot was not received by the Medical Staff office.

- 7.3.2.2. Each office shall be filled by that nominee who receives a simple majority of the votes cast for that position.
- 7.3.2.3. If upon the initial vote no nominee receives a simple majority of the votes cast, then the two nominees receiving the greatest number of votes cast shall be placed upon a special runoff ballot which shall be mailed to all Active-Primary Staff members of the affected hospital as expeditiously as possible. Such ballots must be returned within fifteen (15) days of mailing and the nominee then receiving the simple majority of such votes cast shall fill the office. The same procedures with respect to the ballots and the validity thereof set forth in Section 7.3.2.1 shall be followed.

If as a result of this round of voting, both candidates receive an equal number of votes, then the majority vote of the Medical Executive Committee shall decide the election. The votes of Medical Executive Committee members shall be by secret written ballot at its next meeting or a special meeting called for that purpose. The election shall become effective upon approval of the Board.¹⁵⁷

7.3.3. BOARD APPROVAL/INDEMNIFICATION

To afford the Medical Staff officers and others the full protections of the Healthcare Quality Improvement Act, the Board shall ratify the appointments of Medical Staff officers and other leaders, such as Department and Section officers, who carry out the responsibilities of

¹⁵⁷ MS.01.01.01

their respective offices and positions.¹⁵⁸ The Board's evaluation for purposes of ratification shall be limited to review of qualifications and integrity of election process and the Board's ratification shall serve as confirmation that they are charged with performing important Hospital functions and carrying out the duties of the Medical Staff when engaging in credentialing or quality assessment/performance improvement activities. Such activities shall have the following characteristics:¹⁵⁹

- 7.3.3.1. The activities such leaders undertake shall be performed on behalf of Broward Health;
- 7.3.3.2. The activities shall be performed in good faith;
- 7.3.3.3. That any professional or peer review action shall be taken:
 - 7.3.3.3.1. In the reasonable belief that the action was in the furtherance of quality health care;
 - 7.3.3.3.2. After a reasonable effort to obtain the facts of the matter;
 - 7.3.3.3.3. After adequate notice and hearing procedures are afforded to the individual involved or after such other procedures as are fair to the individual under the circumstances; and,
 - 7.3.3.3.4. In the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting this Section;
- 7.3.3.4. The activities shall follow procedures set forth in these Bylaws, rules and regulations, or policies; and/or,
- 7.3.3.5. Medical Staff leaders who are performing activities meeting the above listed criteria shall qualify for all protections provided by these Bylaws including indemnification and immunity from liability as set forth in Article 11, for those activities through the Broward Health.

7.3.4. ELIGIBILITY FOR RE-ELECTION

No person may serve in the same position for more than two consecutive terms.

¹⁵⁸ 42 U.S.C.S. §11111

¹⁵⁹ 42 U.S.C.S. §11112(a)(1-4)

7.4. VACANCIES

7.4.1. WHEN CREATED

Vacancies in office may occur from time to time, and may include, but not be limited to, any of the following reasons:

- Death of an officer
- Disability of an officer
- Resignation, removal, or recall from office of an officer
- Failure of an officer to maintain Active Staff status in good standing.

7.4.2. FILLING THE OFFICE OF THE CHIEF OF STAFF

When a vacancy occurs in the office of the Chief of Staff, then the Vice Chief of Staff shall serve the remaining term of the former Chief of Staff and the vacancy then created in the office of Vice Chief of Staff shall be filled as described in these Bylaws. In the event of the simultaneous vacancy in both the Chief of Staff and Vice Chief of Staff positions, The MEC shall convene as promptly as possible and appoint interim officers to fill these positions and an election shall be conducted within ninety (90) days. An ad hoc nominating committee appointed by the MEC shall convene within twenty days of the interim appointment to nominate candidates to fill the unexpired terms of office. Following nomination of candidates, a special election shall be conducted for the election of these officers using the election procedures defined in these Bylaws, independent of specific dates, but consistent with designated timelines.

7.4.3. FILLING THE OFFICES OF THE VICE CHIEF OF STAFF, SECRETARY-TREASURER OR THE IMMEDIATE PAST CHIEF OF STAFF

When a vacancy occurs in the office of the Vice Chief of Staff, the Medical Executive Committee shall appoint an interim officer to fill the unexpired term of office. When a vacancy occurs in the office of the Secretary-Treasurer, the Medical Executive Committee shall appoint an interim officer to fill the office until the next regular election. When a vacancy occurs in the office of the Immediate Past Chief of Staff, the office shall remain vacant until after the next election. Notwithstanding the procedures outlined above, in the event of a vacancy of the Immediate Past Chief, the MEC shall appoint a former Chief of Staff to serve the remainder of the term.

7.5. RESIGNATION, REMOVAL, AND RECALL FROM OFFICE

7.5.1. RESIGNATION

Any Medical Staff officer may resign at any time by giving written notice to the Medical Executive Committee and the Chief Executive Officer. Any stipend shall be remitted to the resigning officer on a pro rata basis and any stipend advanced to the resigning officer shall be returned to the entity that advanced the stipend on a pro rata basis.

7.5.2. REMOVAL

Any Medical Staff officer may be removed from office only for cause. Removal shall occur by two-thirds vote of the Medical Executive Committee where there is sufficient evidence for removal from office for cause, and referred to the Board for consideration and approval which approval shall be withheld only upon determination that the MEC misused its authority or otherwise acted arbitrarily or capriciously. For Cause grounds for removal may include any one or more of the following:¹⁶⁰

- 7.5.2.1. Failure to perform the duties of office;
- 7.5.2.2. Failure to comply with or support the enforcement of the Medical Staff Bylaws, Rules and Regulations, or Medical Staff approved policies;
- 7.5.2.3. Failure to support the compliance of the Hospital and the Medical Staff to applicable Federal and State laws and regulations, and the standards or other requirements of any regulatory or accrediting agency having jurisdiction over the Hospital or any of its services;
- 7.5.2.4. Failure to maintain qualifications for office, specifically, failure to maintain active staff status in good standing; and/or,
- 7.5.2.5. Failure to adhere to professional ethics or any other action(s) deemed injurious to the reputation of, or inconsistent with the best interests of Broward Health or the Medical Staff.
- 7.5.2.7. Upon verification by an ad hoc committee appointed by the Medical Executive Committee of grounds for a For Cause termination as set forth in a petition signed by at least seven Active Staff members

¹⁶⁰ MS.01.01.01

7.5.3. RECALL FROM OFFICE

Any Medical Staff officer may be recalled from office only For Cause as set forth in Section 7.5.2. Recall of a Medical Staff officer may be initiated by a majority of members of the Medical Executive Committee or by a petition signed by at least one-third of the medical staff members eligible to vote in medical Staff-Elections setting forth the grounds for For Cause recall from office. Recall shall be considered by the Medical Staff at a special meeting of the Medical Staff called for that purpose and a recall election shall be held within thirty days from the date of the special meeting. Medical Staff members eligible to vote may vote in the recall vote and a recall requires Eighty Percent (80%) of the votes received in the recall election. Sealed and authenticated votes mailed by Medical Staff members eligible to vote shall also be counted at a meeting called for that purpose that may be attended by any eligible voting member and shall be chaired by the Immediate Past Chief of Staff. The recall shall become effective upon approval of the Board.

7.6. RESPONSIBILITIES AND AUTHORITY OF THE ELECTED OFFICERS¹⁶¹

7.6.1. CHIEF OF STAFF

The Chief of Staff shall serve as the Chief Administrative Officer of the Medical Staff. In consideration and acknowledgement for his or her services, the Chief of Staff is authorized to receive an annual stipend for his or her services as authorized by the Joint Conference Committee. He/She shall have responsibility for supervision of the general affairs of the Medical Staff¹⁶² as well as the following responsibilities:

- 7.6.1.1. To represent the Medical Staff to the Chief Executive Officer and the Board of Commissioners in matters of concern to the Medical Staff;
- 7.6.1.2. To communicate and represent the opinions, policies, concerns, needs, and grievances of the Medical Staff to the Chief Executive Officer and the Board, and serve as an ex-officio member of the Board;
- 7.6.1.3. To coordinate with the Chief Executive Officer of the Hospital all matters of mutual concern in the medical care of the patient and the administrative responsibilities of the Hospital;

¹⁶¹ MS.01.01.01

¹⁶² 42 C.F.R. §482.22(b)(3)

- 7.6.1.4. To receive and communicate the opinions, policies, and directives of the Administration and the Board to the Medical Staff;
- 7.6.1.5. To prepare the agenda, call and preside at the general meetings and special meetings of the Medical Staff and the Medical Executive Committee;
- 7.6.1.6. To appoint and discharge the Chairpersons of all Medical Staff standing and ad hoc committees as defined by these Bylaws, recommend to the Medical Executive Committee the members of all Medical Staff standing and ad hoc committees, and appoint Medical Staff members of Hospital and Board committees, consult with the Departmental Chiefs with respect to the establishment of departmental on-call schedules and the substitution or removal of any member from the schedule. With respect to any Member providing on-call services by contractual agreement with Broward Health, such decision to substitute or remove said Member is retained by the CEO, who shall coordinate the effect of any decision on the on-call services schedule with the Department Chair and the Chief of Staff;
- 7.6.1.7. To serve as ex-officio member of all other Medical Staff committees without vote, unless otherwise specified;
- 7.6.1.8. To act as the representative of the Medical Staff to the public as well as to other health care providers, other organizations, and regulatory or accrediting agencies in external professional and public relations;
- 7.6.1.9. To coordinate the educational activities of the Medical Staff;
- 7.6.1.10. To ensure enforcement of all actions of the Medical Executive Committee and to ensure staff compliance with all Bylaws of the Medical Staff Rules and Regulations, Departmental Rules and Regulations for each hospital and the Medical Staff approved policies and procedures of Broward Health;
- 7.6.1.11. To implement sanctions when indicated, and enforce the Medical Staff's compliance with procedural safeguards in all instances in which corrective action has been requested or initiated against a Practitioner or other individual with clinical privileges;
- 7.6.1.12. To suspend members of the Medical Staff as outlined in these Bylaws;

- 7.6.1.13. To grant temporary privileges as outlined in these Bylaws;
- 7.6.1.14. To oversee the MEC's functions in considering and recommending clinical privileges for each member of the Medical Staff or other individual requesting clinical privileges.¹⁶³ If the Chief of Staff is in direct economic competition with the applicant, then the Chief of Staff should not participate in such recommendation, but should delegate this responsibility to the Vice Chief of Staff;
- 7.6.1.15. To oversee and participate in the professional review of the professional performance of all individuals who have clinical privileges;¹⁶⁴
- 7.6.1.16. To serve as a member of the Joint Conference Committee and Bylaws Sub-Committee;
- 7.6.1.17. To be accountable and responsible to the Board for the quality and efficiency of clinical services and professional performance of the Medical Staff in the provision of patient care services;
- 7.6.1.18. To confer with the Chief Executive Officer, Chief Financial Officer, Chief Nursing Officer, and Section Chief on at least a quarterly basis as to whether there exists sufficient space, equipment, staffing, and financial resources or that the same will be available within a reasonable time to support each privilege requested by applicants to the Medical Staff; and report on the same to the MEC, Unified Medical Staff Council, and to the Board;¹⁶⁵
- 7.6.1.19. To assist the Section Chief as to the types and amounts of data to be collected and compared in determining and informing the Medical Staff of the professional practice of its members;¹⁶⁶
- 7.6.1.20. To perform all other functions as may be within the scope of the Chief of Staff's responsibilities pursuant to these Bylaws,

¹⁶³ MS.06.01.07; MS.08.01.03

¹⁶⁴ MS.06.10.07; MS.08.01.03

¹⁶⁵ MS.06.01.01 requires the hospital adopt a process to determine whether there exists sufficient space, equipment, staffing, and financial resources or that the same will be available within a time certain to support each privilege requested/granted. The process is satisfied by a quarterly documented conference that verifies the existence of such resources for each privilege offered in the hospital.

¹⁶⁶ MS.08.01.01 requires the medical staff determine the types and amounts of data to rely upon in both ongoing and focused professional practice evaluation.

and such other functions as may be requested of the Chief of Staff by the MEC, CEO or the Board, and agreed to by him or her in furtherance of the responsibilities of the Medical Staff.

7.6.2. VICE CHIEF OF STAFF

The Vice Chief of Staff shall perform the duties of the Chief of Staff in the absence or temporary inability of the Chief of Staff to perform. The Vice Chief of Staff shall serve as the vice-chairperson of the Medical Executive Committee and shall perform such additional duties as may be requested by the Chief of Staff or MEC, which shall include, but is not limited to, the following.

- 7.6.2.1. Serve as a member of the Joint Conference Committee and Unified Medical Staff Committee; and,
- 7.6.2.2. Act as Chairperson of the Medical Care Evaluation Committee or such similarly purposed committee, if the Hospital and MEC deems such Committee to be necessary.

7.6.3. SECRETARY-TREASURER

The Secretary-Treasurer shall be a member of the Medical Executive Committee. The duties of the Secretary-Treasurer shall include but are not limited to:

- 7.6.3.1. Assure that accurate and complete minutes of all general Medical Staff and Medical Executive Committee meetings are kept, call meetings upon order of the Chief of Staff, attend to all correspondence, assure the maintenance of accurate attendance records of regular and special meetings of the Medical Staff, and report delinquencies in attendance requirements to the Medical Executive Committee at its monthly meeting;
- 7.6.3.2. Maintain current records of Medical Staff funds and submit a financial report at the Annual General Staff Meeting of the Medical Staff and attend to all appropriate correspondence and notices on behalf of the Medical Staff;
- 7.6.3.3. Maintain a record of Medical Staff dues, collections, and accounts, and sign checks for the Medical Staff fund expenditures pursuant to his/her authority;
- 7.6.3.4. Maintain a roster of Medical Staff members; and,

7.6.3.5. Assure that all notices of Medical Staff meetings are given as provided in these Bylaws, on order of the Chief of Staff.

7.6.4. IMMEDIATE PAST CHIEF OF STAFF

As an individual with unique knowledge of Medical Staff affairs, the Immediate Past Chief of Staff shall serve as an advisor and mentor to the Chief of Staff, shall serve as Chairperson of the Nominating Committee, shall participate as a member of the Medical Executive Committee and other standing committees of the Medical Staff as specified in these Bylaws, and shall perform other duties as requested by the Chief of Staff.

7.6.5. CONFLICT OF INTEREST AMONG MEDICAL STAFF LEADERS¹⁶⁷

The best interest of the community, Medical Staff and the Hospital are served by Medical Staff leaders (defined as any member of the Medical Executive Committee, officer of the Medical Staff, member of Credentials and Qualifications or any mandated Quality or Professional Review Committee, and/or members of the Medical Staff who are also members of the Board of Commissioners) who are objective in the pursuit of their duties, and who exhibit that objectivity at all times to avoid the appearance of impropriety due to personal, financial or professional conflicts of interest or potential conflicts of interest arising from the relationships of any Medical Staff leader with Broward Health or such other direct economic relationships adverse to Broward Health. Therefore, it is considered to be in the best interest of the Hospital and the Medical Staff for relationships of any Medical Staff leader which may influence the decisions related to the Hospital and/or the Medical Staff to be disclosed on a regular and contemporaneous basis.

Recognizing that the Medical Staff leadership is also engaged in the practice of medicine and the attendant professional efforts and benefits arising thereof, no Medical Staff leader shall use his/her position to obtain or accrue any benefit of a solely personal nature. Semi-annually, on or before May 1 and January 15, each Medical Staff leader shall complete and submit to the MEC a Conflict of Interest Disclosure form approved by UMSC and the Board.

A new Medical Staff leader shall complete and submit the Conflict of Interest Disclosure form within ten business days of being elected or appointed to his/her leadership position, if such form is not otherwise already submitted to MEC. In providing the information sought by the Conflict of Interest Disclosure form, the Medical Staff leader shall

¹⁶⁷ LD.02.02.01

interpret the requests for information broadly in the spirit of full disclosure. This disclosure procedure will not require any action which would be deemed a breach of any state or federal confidentiality law, but in such circumstances, minimum allowable disclosures should be made.¹⁶⁸

Between bi-annual disclosure dates, any new relationship of the type requested for disclosure on the Conflict of Interest Disclosure form, shall be disclosed in writing to the MEC by the next regularly scheduled MEC meeting. The MEC Secretary will provide each MEC member with a copy of each member's written disclosure at the next MEC meeting following filing by the member for review and discussion by the MEC.

Medical Staff leaders shall abstain from voting on or participating in the discussion of any issue in which the Medical Staff leader could reasonably be said to have a direct conflict of interest based upon the result of the vote or the ultimate decision to be made on the issue before the Medical Staff leader. A breach of these provisions may constitute grounds for removal of a breaching member from any Medical Staff Committee by the Unified Medical Staff Committee. Any request by a Medical Staff member, Administrator or the Board to investigate a possible breach of this Section shall be made to UMSC, which shall promptly investigate and determine at a specially called meeting whether a conflict of interest exists and, if so, recommend any corrective action.

ARTICLE VIII. CLINICAL DEPARTMENTS AND SPECIALTY DIVISIONS

8.1. DESIGNATION

Each Broward Health Hospital will establish Departments according to the needs of the individual Hospital. The specialties under each established Department will be listed in the Departmental Rules and Regulations of each Hospital and at a minimum will contain the following clinical Medical Staff Departments: Medicine/Family Practice, and Surgery.

8.1.1. ORGANIZATION OF DEPARTMENTS

Each Department of each Broward Health Hospital shall be organized as a separate part of the Medical Staff of that Hospital.

8.1.2. SPECIALTY SECTIONS WITHIN A DEPARTMENT

¹⁶⁸ §456.057, F.S.

Each Department may be further subdivided into specialty Sections.¹⁶⁹

8.1.3. DEPARTMENT AND SPECIALTY SECTIONS

Departments or sections may include, but not be limited to, the following:

- 8.1.3.1. Cardiology
- 8.1.3.2. Emergency Medicine
- 8.1.3.3. Family Practice
- 8.1.3.4. Gastroenterology
- 8.1.3.5. Internal Medicine
- 8.1.3.6. Psychiatry
- 8.1.3.7. Radiology
- 8.1.3.8. Anesthesiology
- 8.1.3.9. Otolaryngology
- 8.1.3.10. General Surgery
- 8.1.3.11. Ophthalmology
- 8.1.3.12. Orthopedics
- 8.1.3.13. Podiatry
- 8.1.3.14. Pathology
- 8.1.3.15. Plastic Surgery
- 8.1.3.16. Urology
- 8.1.3.17. Hematology/Oncology
- 8.1.3.18. Cardiothoracic Surgery
- 8.1.3.19. Cardiovascular Surgery
- 8.1.3.20. Neonatology
- 8.1.3.21. Obstetrics/Gynecology
- 8.1.3.22. Pediatrics
- 8.1.3.23. Geriatrics
- 8.1.3.24. Neurology
- 8.1.3.25. Neurosurgery
- 8.1.3.26. Medical Oncology
- 8.1.3.27. Radiation Oncology
- 8.1.3.28. Endocrinology
- 8.1.3.29. Nephrology
- 8.1.3.30. Immunology
- 8.1.3.31. Dermatology
- 8.1.3.32. Dentistry

8.2. CRITERIA TO QUALIFY AS A DEPARTMENT OR SECTION

Upon consultation with the CEO or his/her designated representative(s), the Medical Executive Committee may recommend to the Board to create, eliminate, subdivide or combine Departments or Sections, subject to these Bylaws, based

¹⁶⁹ MS.01.01.01; MS.06.01.07; LD.04.01.05

on the evolving scope of clinical services of the Hospital and the need of the Medical Staff organization to most effectively support the oversight of quality of patient care. The Board shall approve such recommendation absent a determination the recommendation is not in the best interest of the Hospital's operations or patient care or is otherwise in violation of the Bylaws or is arbitrary or capricious. Since the primary function of a Department or a Section is to be responsible for the quality of patient care provided by the members of the Department or Section, the primary criteria for creating or subdividing a Department or Section, or in eliminating or combining a Department or Section shall be whether the Department or Section has a sufficient number of active staff members and sufficient patient volume to support the quality assessment and performance improvement activities required of a Department or Section.

New Departments or Sections may be activated as the need arises by majority vote of the Medical Executive Committee of the affected hospital, with appropriate revisions to the applicable Departmental Rules and Regulations.

8.2.1. CRITERIA TO QUALIFY AS A NEW DEPARTMENT

- 8.2.1.1. Each Department of each hospital may establish written rules for the organization and functioning of the Department, which shall not be in conflict with these Bylaws, and the Rules of the Broward Health Medical Staffs.
- 8.2.1.2. The rules for each Department shall be approved by the Medical Executive Committee and the Board of Commissioners.
- 8.2.1.3. Such rules shall, at a minimum, provide for regular Departmental meetings; duties and assignment of members; the general organization of the Department, and criteria for membership in that Department.
- 8.2.1.4. The rules of each Department may differ from other Departments except that those rules specifically relating to the criteria for granting clinical privileges must be uniform in all Hospitals.
- 8.2.1.5. The criteria for clinical privileges shall be established by joint meetings of key representatives, from each specialty chosen by each Chief of Staff. The criteria will be presented to the Credentials and Qualifications Committee of each Hospital and each Medical Executive Committee for approval.
- 8.2.1.6. Assignment to Departments will be made by the Medical Executive Committee based on the advice received from the

specific Department to the Credentials and Qualifications Committee and, if the Member requests and is appropriately qualified, may be assigned to more than one Department.

- 8.2.1.7. Clinical privileges will be recommended by the Medical Executive Committee to the Board of Commissioners based on the advice received from the specific Department through the Credentials and Qualifications Committee.

8.2.2. CRITERIA TO QUALIFY AS A SECTION

To qualify as a Section, there shall be sufficient active staff members in a clinically distinct area of medical practice with sufficient patient volume to support the occasional need of these specialists to deliberate quality of care issues unique to their specialty.

8.3. REQUIREMENTS FOR AFFILIATION WITH DEPARTMENTS AND SECTIONS

Each Medical Staff member and other individuals with clinical privileges shall be assigned to one Department by the Board based on recommendations from the Medical Executive Committee. A Medical Staff member or other individual with clinical privileges may be assigned to a Section if one exists related to the member's or individual's clinical specialty. A member or other individual with clinical privileges may be granted clinical privileges in one or more other Departments. The exercise of clinical privileges within any Department shall be subject to the rules and regulations of the Department and the authority of the Department Chairperson.

8.4. FUNCTIONS OF DEPARTMENTS

The Departments shall meet to perform the following functions:

8.4.1. CLINICAL FUNCTIONS

- 8.4.1.1. Serve as a forum for the exchange of clinical information regarding services provided by Department members;
- 8.4.1.2. Provide recommendations to the Department Chairperson and/or the Medical Executive Committee with regard to the development of clinical practice guidelines related to care and services provided by Department members;
- 8.4.1.3. Provide recommendations to the Department Chairperson regarding professional criteria for the granting, withdrawing and modifying of clinical privileges designed to assure the

Medical Staff and Board that patients shall receive quality care.¹⁷⁰

8.4.1.4. Ensure that patients receive appropriate and medically necessary care from a member of the Medical Staff during the entire length of stay with the Hospital;¹⁷¹

8.4.1.5. Ensure that the same level of quality of patient care is provided by all individuals with delineated clinical privileges, within the Department, across Departments, and between members and non-members of the Medical Staff with clinical privileges;¹⁷²

8.4.1.5.1. By establishing uniform patient care processes;¹⁷³

8.4.1.5.2. By establishing similar clinical privileging criteria for similar privileges;¹⁷⁴ and,

8.4.1.5.3. By using similar indicators in performance improvement activities.¹⁷⁵

8.4.1.6. Provide recommendations to the Department Chairperson and/or the Medical Executive Committee with regard to issues related to standards of practice and/or clinical competence; and,

8.4.1.7. Ensure effective mechanisms for the clinical supervision of Allied Health Professionals, and House Staff practitioners, if any.

8.4.2. ADMINISTRATIVE FUNCTIONS

8.4.2.1. Provide information and/or recommendations to the Department Chairperson with regard to the criteria for granting clinical privileges within the Department;

8.4.2.2. Ensure that individuals within the Department who admit patients have privileges to do so,¹⁷⁶ and that all individuals

¹⁷⁰ MS.02.01.01; MS.06.01.07

¹⁷¹ MS.03.01.01

¹⁷² LD.01.05.01

¹⁷³ LD.04.03.07

¹⁷⁴ LD.01.05.01

¹⁷⁵ LD.01.05.01

¹⁷⁶ MS.03.01.01; MS.06.01.07

within the Department with clinical privileges only provide services within the scope of privileges granted;¹⁷⁷

8.4.2.3. Provide information and/or recommendations to the Department Chairperson and/or the Medical Executive Committee with regard to Medical Staff policies and procedures; and,

8.4.2.4. (Administrative Functions of Departments): Provide recommendations to the Department Chairperson, the Medical Executive Committee, and/or the Chief Executive Officer with regard to ensuring appropriate call coverage by Department members.

8.4.3. QUALITY ASSESSMENT/PERFORMANCE IMPROVEMENT AND PATIENT SAFETY ACTIVITIES

8.4.3.1. Perform peer review and quality assessment activities relative to the performance of individuals with clinical privileges in the Department and report such activities to the Medical Executive Committee or such other appropriately designated peer review or quality assessment Committee on a regular basis;

8.4.3.2. Provide leadership for activities related to patient safety, including proactive risk assessments, root cause analysis in response to an unanticipated adverse event, addressing patient safety alerts, complying with quality process measures as required by regulatory agencies and third party payers, and implementing procedures to comply with patient safety goals;¹⁷⁸

8.4.3.3. Ensure appropriate quality control is performed, if applicable to the Department; and,

8.4.3.4. Receive reports regarding Hospital performance improvement results that are applicable to the performance of the Department and its members, and integrate the Department's performance improvement activities with that of the Hospital by taking a leadership and participatory role in such activities, as outlined in the Hospital Performance Improvement Plan.

8.4.4. COLLEGIAL AND EDUCATIONAL FUNCTIONS

¹⁷⁷ MS.08.01.03

¹⁷⁸ MS.03.01.03; 42 C.F.R. §482.22

- 8.4.4.1. Recommend medical educational programs to meet the needs of Department members, based on the scope of services provided by the Department, changes in medical practice or technology, quality initiatives, and the results of Departmental performance improvement activities.¹⁷⁹

8.5. FUNCTIONS OF SECTIONS

The Sections shall meet as often as necessary at the call of the Section Chief to perform the following functions:

- 8.5.1. The Section meetings shall serve as a forum to discuss clinical aspects of care related to the Section;
- 8.5.2. The Section may be requested by the Department Chairperson or Medical Executive Committee to meet to discuss specific issues related to quality assessment, peer review, performance improvement, and/or credentialing. In such cases, the Section shall report their findings directly to the Department Chairperson or the Medical Executive Committee.

8.6. OFFICERS OF DEPARTMENTS AND SECTIONS

8.6.1. IDENTIFICATION

Each Department shall have a Chairperson, Vice Chairperson and other officers as specified in the Rules and Regulations at each Hospital. Each Section shall have a Section Chief.

8.6.2. QUALIFICATIONS

- 8.6.2.1. Departmental or Sectional Officers must be certified by the appropriate specialty board or have affirmatively established comparable competency, must be Active-Primary members of a clinical Department of the Medical Staff at the Hospital in which they are nominated, must be skilled managing conflict resolution, and must remain members in good standing during their term of office. Failure to maintain such status shall create an immediate vacancy in that particular office.¹⁸⁰
- 8.6.2.2. Nominees for Departmental or Sectional Offices may only be nominated and serve at one Broward Health hospital per term.
- 8.6.2.3. The Section Chief shall have demonstrated ability in the

¹⁷⁹ MS.12.01.01

¹⁸⁰ MS.01.01.01; MS.06.01.07; LD.04.01.05

specialty represented by the Section.

8.6.3. ATTAINMENT OF OFFICE

8.6.3.1. NOMINATION

8.6.3.1.1. The Departmental Nominating Committee shall offer nominees for Department Chairperson, Department Vice Chairperson, and other officers as may be delineated by the Rules and Regulations of the Department. After approval by the Department, the slate of nominees shall be presented for approval to the Medical Executive Committee of the applicable hospital at its January meeting. The Medical Executive Committee shall review and approve the nominees recommended by the Departmental Nominating Committee to determine they meet the qualifications set forth in the Bylaws and in the event any nominee is not approved, the MEC shall direct the Nominating Committee to propose another nominee at the February meeting. In the event any additional nominee recommended by the Nominating Committee for consideration at the February MEC meeting is not approved as to said qualifications, the MEC shall select the remaining nominee(s) at the February meeting and the names of the nominees shall be posted in the applicable hospital's Medical Staff bulletin board no later than one week after the February MEC meeting.

Nominations may also be made by petition signed by at least ten percent of the active members of the Department, with a signed statement of willingness to serve by the nominee, submitted to the Chief of Staff no later than the last business day in February. As soon thereafter as reasonably possible, the names of the additional nominees will be reported to the Members of the Department, but in no event later than March 23rd.

8.6.3.1.2. No person shall be nominated to more than one office, nor without the consent of the nominee. Thereafter nominations shall be closed. Nominations shall remain confidential until approved by the MEC and it confirms the nominees consent to run for office.

8.6.3.2. ELECTION.

Departmental elections shall be conducted in the same manner set forth in Section 7.3.1.3 governing elections for officers of the Medical Staff.

8.6.3.3. BOARD APPROVAL/INDEMNIFICATION

To afford the Department officers and other Members of the Medical Staff who carry out their duties as an officer or member of the Medical Staff, its departments or committees the full protections of the Healthcare Quality Improvement Act and such other indemnifications and protections as provided by these Bylaws and federal and state law, the Board shall ratify the appointments of the Medical Staff and Department officers. Such evaluation for purposes of ratification shall be limited to review of qualifications and integrity of the election process and the Board's ratification shall confirm the intent and agreement of the Board to fully defend, indemnify and hold harmless the officers of the Medical Staff and its Departments, the MEC and such other members of the Medical Staff who are named or otherwise sued in state or federal court or who are joined in any administrative or governmental proceeding or investigation carried out by a federal or state agency or regulatory entity charged with enforcement of any such state or federal law, for any alleged act or omission undertaken by the officer, Member or Committee member of the Medical Staff within the scope or course of scope of his or her duties in carrying out the functions of the Medical Staff, including administrative-medical staff matters, quality assessment/performance improvement activities, including credentialing and any professional review action, corrective action investigation and any subsequent fair hearing or appellate review action undertaken pursuant to these Bylaws.¹⁸¹ This binding agreement to provide such indemnification and defense is subject to such action having been undertaken: a) in good faith; b) upon reasonable belief the action taken was in furtherance of quality health care; c) after reasonable effort to obtain the facts applicable to the matter; and in substantial compliance with the procedures for Corrective Action and Hearing and Appellate Review Procedures set forth in these Bylaws, as applicable¹⁸² Notwithstanding the above, the Board shall not be required to

¹⁸¹ 42 USCS §11111

¹⁸² 42 USCS §11112(a)(1-4)

defend, indemnify, and hold harmless the officers of the Medical Staff and its Departments, the MEC and other such members of the Medical Staff who are named plaintiffs or relators in an action against Broward Health, its employees or agents, any of its affiliates or any of the Medical Staffs. The Board retains the right to select the counsel to represent the Medical Staff member in any action for which the Board indemnifies the member.

8.6.3.4. ELIGIBILITY FOR RE-ELECTION

No person may serve in the same position for more than two consecutive terms and no person may simultaneously hold office as an officer of the Medical Staff and a Departmental officer.

8.6.4. VACANCIES

8.6.4.1. WHEN CREATED

Vacancies in office may occur from time to time, and may include, but not be limited to, any of the following reasons:

- Death of an officer;
- Disability of an officer;
- Resignation, removal, or recall from office of an officer;
- or,
- Failure of an officer to maintain Active Staff status in good standing.

8.6.4.2. FILLING THE OFFICE OF THE DEPARTMENT CHAIRPERSON

When a vacancy occurs in the office of the Department Chairperson, then the Department Vice Chairperson shall serve the remaining term of the former Department Chairperson. The vacancy then created in the office of Department Vice Chairperson shall be filled as described in these Bylaws. In the event of the simultaneous vacancy in both the Department Chairperson and the Department Vice Chairperson positions, or in all of the officer positions, the MEC shall convene as promptly as possible and appoint interim officers to fill these positions and an election shall be conducted within ninety (90) days. An ad hoc nominating committee appointed by the MEC shall convene within twenty days of the interim appointment to nominate candidates to fill the unexpired terms of office. Following nomination of

candidates, a special election shall be conducted for the election of these officers using the election procedures defined in these Bylaws, independent of specific dates, but consistent with designated timelines.

8.6.4.3. FILLING THE OFFICES OF THE DEPARTMENT VICE CHAIRPERSON, OR DEPARTMENT SECRETARY

When a vacancy occurs in the office of the Department Vice Chairperson, the Medical Executive Committee shall appoint an interim officer to fill the office for up to 90 days. The Nominating Committee shall convene as soon as possible to nominate candidates to fill the unexpired terms of the Department Vice Chairperson office. Following nomination of candidates, a special election shall be conducted for the election of the Department Vice Chairperson using the election procedures defined in these Bylaws, independent of specific dates, but consistent with designated timelines. When a vacancy occurs in the office of the Department Secretary, the Medical Executive Committee shall appoint an interim officer to fill the office until the next regular election.

8.6.5. RESIGNATION, REMOVAL, AND RECALL FROM OFFICE

8.6.5.1. RESIGNATION

Any Department officer may resign at any time by giving written notice to the Medical Executive Committee and the Chief Executive Officer, and the acceptance of such resignation shall not be necessary to make it effective.

8.6.5.2. REMOVAL

Any Department officer may be removed from office for cause. Removal shall occur by two-thirds vote of the Medical Executive Committee as to whether there is sufficient evidence for removal from office for cause, with approval by the Board, which approval shall be withheld only upon determination that the MEC misused its authority or otherwise acted arbitrarily or capriciously. Grounds for removal may include any one or more of the following causes, without limitations:¹⁸³

8.6.5.2.1. Failure to perform the duties of office;

¹⁸³ MS.01.01.01

- 8.6.5.2.2. Failure to comply with or support the enforcement of the Medical Staff Bylaws, Rules and Regulations, or Medical Staff approved policies;
- 8.6.5.2.3. Failure to maintain qualifications for office, specifically, failure to maintain active staff status in good standing.
- 8.6.5.2.4. Failure to adhere to the applicable professional ethical standards; or:
- 8.6.5.2.5. Such removal may be effectuated upon the recommendation of a two-thirds vote of the Medical Executive Committee upon receipt of a petition signed by at least seven Active Staff members of the subject Department and verification by the Medical Executive Committee or an ad hoc committee appointed by the MEC of the veracity of the factual grounds presented in the petition for removal facts stated in the petition.

8.6.5.3. RECALL FROM OFFICE

Any Department officer may be recalled from office, with cause. Recall of a Department officer may be initiated by a majority of its members or by a petition signed by at least one-third of the Department members eligible to vote in Department Elections. Recall shall be considered by the Department at a special meeting of the Department called for that purpose and notice of which shall be given by regular and electronic mail. A recall shall require two-thirds of the votes of the Department members attending the specially called meeting who are eligible to vote. Sealed and authenticated votes mailed by Department members eligible to vote shall also be counted at the special meeting. The recall shall become effective upon approval of the Board.

8.6.6. RESPONSIBILITY AND AUTHORITY¹⁸⁴

- 8.6.6.1. Department Chairperson: Each Department Chairperson shall be responsible for the organization of the Department and delegation of duties to Department members to promote quality of patient care in the Department. Members of the Department and others with clinical privileges in the

¹⁸⁴ MS.01.01.01; MS.06.01.07; LD.04.01.05

Department shall be responsible to the Department Chairperson.

The Chairperson of each Department will be accountable to the Medical Executive Committee of the Hospital and will have the following responsibilities:

- 8.6.6.1.1. Coordinates professional and Medical Staff administrative activities within the Department;
- 8.6.6.1.2. Implements actions taken by the Medical Executive Committee within the Department;
- 8.6.6.1.3. Reports regularly to the Medical Executive Committee;
- 8.6.6.1.4. Participates in the evaluation of Practitioners practicing within the department;¹⁸⁵
- 8.6.6.1.5. Oversees all clinically related activities of the Department;¹⁸⁶
- 8.6.6.1.6. Serve as a member of the Medical Executive Committee and be accountable to the Medical Executive Committee with regard to the activities and functioning of the Department, specifically to regularly report the quality assessment and performance improvement activities of the Department to the Medical Executive Committee;
- 8.6.6.1.7. Coordinates and integrates interdepartmental and intradepartmental services;¹⁸⁷
- 8.6.6.1.8. Develops and implements policies and procedures with the support of the Chief Executive Officer and other appropriate departments that guide and support the provision of care, treatment, and services;
- 8.6.6.1.9. Conducts all administratively related activities of the Department, unless otherwise provided by the Hospital;¹⁸⁸

¹⁸⁵ MS.01.01.01; MS.06.01.07; LD.04.01.05

¹⁸⁶ MS.01.01.01; MS.06.01.07; LD.04.01.05

¹⁸⁷ MS.01.01.01; LD.04.01.05; LD.03.06.01; LD.03.03.01; LD.04.01.11; LD.04.01.07; LD.03.05.01; LD.04.04.01

¹⁸⁸ MS.01.01.01; MS.06.01.07; LD.04.01.05

- 8.6.6.1.10. Participate in ongoing review of the professional performance of all individuals in the Department who have delineated clinical privileges;¹⁸⁹
- 8.6.6.1.11. Makes recommendations for the criteria for clinical privileges for each Department;
- 8.6.6.1.12. Assesses and recommends to the relevant hospital authority off-site sources for needed patient care, treatment, and services not provided by the department or the organization;
- 8.6.6.1.13. Is responsible for the integration of the department or service into the primary functions of the organization;
- 8.6.6.1.14. Makes recommendations for a sufficient number of qualified and competent persons to provide care, treatment and services;
- 8.6.6.1.15. Oversee the determination of the qualifications and competence of department or service personnel who are not licensed independent practitioners and who provide patient care, treatment, and services;
- 8.6.6.1.16. Participates in the continuous assessment and improvement of the quality of care and services provided;¹⁹⁰
- 8.6.6.1.17. Participates in the establishment and maintenance of quality control programs, as appropriate;¹⁹¹
- 8.6.6.1.18. Oversees the orientation and continuing education of all persons in the Department;¹⁹²
- 8.6.6.1.19. Recommends space and other resources needed by the department or service;

¹⁸⁹ MS.01.01.01; MS.06.01.07; LD.04.01.05

¹⁹⁰ MS.01.01.01; LD.04.01.05; LD.03.06.01; LD.03.03.01; LD.04.01.11; LD.04.01.07; LD.03.05.01; LD.04.04.01

¹⁹¹ MS.01.01.01; LD.04.01.05; LD.03.06.01; LD.03.03.01; LD.04.01.11; LD.04.01.07; LD.03.05.01; LD.04.04.01

¹⁹² MS.01.01.01; LD.04.01.05; LD.03.06.01; LD.03.03.01; LD.04.01.11; LD.04.01.07; LD.03.05.01; LD.04.04.01

- 8.6.6.1.20. Presides at all meetings of the Department;
- 8.6.6.1.21. Appoints Department members to the positions of Section Chief and to membership positions on Departmental committees, if any; and,
- 8.6.6.1.22. May serve as an ex-officio member of all departmental committees if any, without vote, unless specifically state in the Bylaws or Rules and Regulations otherwise.
- 8.6.6.1.23. (Responsibility and Authority – Department Chairperson) Establishes departmental on-call schedule including the substitution or removal of any Departmental member, upon consultation with the Chief of Staff. With respect to any Member providing on-call services by contractual agreement with Broward Health, such decision to substitute or remove said Member is retained by the CEO, who shall coordinate the effect of any decision on the on-call services schedule with the Department Chair and the Chief of Staff.
- 8.6.6.2. Department Vice Chairperson: The Department Vice Chairperson shall have the following responsibilities:
 - 8.6.6.2.1. Assumes all of the duties and authority of the Department Chairperson in his/her absence; and,
 - 8.6.6.2.2. Fulfills all of the responsibilities as specified in these Bylaws, Rules and Regulations or as requested by the Department Chairperson.
- 8.6.6.3. Department Secretary: The Department Secretary shall have the following responsibilities:
 - 8.6.6.3.1 The Department Secretary shall be responsible for overseeing the minutes and records of the Department.
- 8.6.6.4 Section Chief: The Section Chief shall be responsible for promoting quality of patient care in the Section. Each Section Chief shall be responsible for the following duties:
 - 8.6.6.4.1. Calls and gives notice of a meeting of the Section members, to be held on an ad hoc basis, when

issues are identified that require the members to deliberate quality of care issues unique to their specialty. The Section Chief shall preside at all of the meetings of the Section; and,

- 8.6.6.4.2. Is accountable to the Department Chairperson with regard to the activities and functioning of the Section, specifically to report any quality assessment and performance improvement activities of the Section at the meetings of the Department.

8.7 REQUIREMENTS FOR HISTORY AND PHYSICAL EXAM

8.7.1 History and Physical Exam

- 8.7.1.1 The physician on whose service the patient is admitted shall be responsible to provide, write or dictate the history and physical. Reports shall be completed and entered in the medical record within twenty-four (24) hours of admission, including weekends and holidays. If surgery is to be performed in less than twenty-four (24) hours, the history and physical shall be recorded and included in the medical record prior to surgery.
- 8.7.1.2 A history and physical performed by any member of the Medical Staff within thirty (30) days prior to admission may be accepted in the patient's medical record, provided:
- 8.7.1.3 It is updated within twenty-four (24) hours after admission or prior to relevant procedures regardless of whether there were changes in the patient's status (an appropriate assessment includes a physician examination of the patient to update components of the patient's current medical status that may have changed since the prior H&P or to address any areas where more current data is needed, confirming that the necessity for the procedure or care is still present and the H&P is still current).
- 8.7.1.4
- 8.7.1.5 Exceptions:
- 8.7.1.6 An interval history and physical report, reflecting changes from previous examination, may be used in the case of a patient's readmission within seven (7) days from the date of original history and physical for the same or related problem.

- 8.7.1.7 The history shall include the chief complaint, details of present illness, relevant past medical history, family and social histories appropriate to the patient's age, a summary of the patient's psychosocial needs, as appropriate to the patient's age, and an inventory by body system.
- 8.7.1.8 The physical examination shall include a relevant current physical examination covering each of the body systems with particular attention to the system involved with the chief complaint. Pertinent normal and abnormal findings and impressions should be included.
- 8.7.1.9 A statement of the conclusions or impressions drawn from the admission history and physical examination shall be noted.
- 8.7.1.10 A statement of the course of action planned for the patient for this episode of care and of its periodic review, as appropriate, shall be noted.

ARTICLE IX. FUNCTIONS AND COMMITTEES

9.1. GOVERNANCE

The Medical Staff is an integral part of the Hospital and is a self-governing legal entity for the purposes of carrying out its organized and delineated responsibilities and functions. As such, these Bylaws create a legally binding and enforceable system of rights and responsibilities between the organized Medical Staff and the Governing Body. The Medical Staff organization shall:

- 9.1.1.1. Establish a framework for self-governance of Medical Staff activities and accountability to the Board per its Bylaws, Rules and Regulations and Medical Staff approved policies.¹⁹³
- 9.1.1.2. Establish a mechanism for the Medical Staff to communicate with all levels of governance involved in policy decisions affecting patient care services in Broward Health.¹⁹⁴

9.1.2. PLANNING

Medical Staff leaders shall participate individually and collectively in collaborating with other Hospital leaders in the performance of the following leadership planning activities:

¹⁹³ MS.01.01.01; MS.01.01.03

¹⁹⁴ MS.03.01.03; LD.01.01.01; LD.01.03.01; LD.02.01.01; LD.03.04.01

- 9.1.2.1. Planning patient care services;¹⁹⁵
- 9.1.2.2. Planning and prioritizing performance improvement activities;¹⁹⁶
- 9.1.2.3. Budgeting;¹⁹⁷
- 9.1.2.4. Providing for uniform performance of patient care processes, including providing a mechanism to ensure that the same level of quality of patient care is provided by all individuals with delineated clinical privileges, within Medical Staff Departments, across Departments, and between members and non-members of the Medical Staff who have delineated clinical privileges;¹⁹⁸
- 9.1.2.5. Recruitment, retention, development, and continuing education of all staff;¹⁹⁹
- 9.1.2.6. Consideration and implementation of clinical practice guidelines as appropriate to the patient population;²⁰⁰
- 9.1.2.7. System-wide strategic planning; and,
- 9.1.2.8. Advice about the source of clinical services that are to be provided through contractual agreements.²⁰¹

9.1.3. CREDENTIALING

The Medical Staff is accountable to the Board for the credentialing process as more fully defined and set forth in Articles II, III and IV.

9.1.4. QUALITY ASSESSMENT/PERFORMANCE IMPROVEMENT AND PATIENT SAFETY

The Medical Staff is accountable to the Board in carrying out its responsibilities with respect to the quality of care provided to patients as specified in these Bylaws.²⁰² All Medical Staff members and all others with delineated clinical privileges shall be subject to periodic review and appraisal as part of the Hospital's quality assessment and performance

¹⁹⁵ LD.02.01.01; LD.03.02.01; LD.03.03.01; LD.04.03.01

¹⁹⁶ PI.03.01.01; LD.03.03.01; LD.03.05.01; LD.04.04.01

¹⁹⁷ LD.04.01.03

¹⁹⁸ LD.02.01.01; LD.03.02.01; LD.03.03.01; LD.04.03.01; LD.01.05.01

¹⁹⁹ LD.02.01.01; LD.03.02.01; LD.03.03.01; LD.04.03.01; LD.03.06.01

²⁰⁰ LD.04.04.07

²⁰¹ LD.04.03.09

²⁰² 42 C.F.R. §482.12(a)(5)

improvement activities and the Medical Staff shall participate in the evaluation of all organized services related to patient care.²⁰³ Through the activities of the Medical Staff Departments and Sections, the Medical Staff Quality/Peer Review Committees or such other quality/peer review committees organized per these Bylaws, and representation of the Medical Staff on Hospital performance improvement committees and teams, the Medical Staff shall perform the roles in quality assessment and performance improvement that are listed below.²⁰⁴ The Medical Staff shall ensure that the findings, conclusions, recommendations, and actions taken to improve organization performance are communicated to appropriate Medical Staff members or committees, Administration and, as applicable, to the Board of Commissioners.²⁰⁵

9.1.4.1. The Medical Staff shall participate with the Board and Administration in the performance of executive responsibilities related to the Hospital quality assessment and performance improvement program for the purpose of ensuring the following:²⁰⁶

9.1.4.1.1. That an ongoing program for quality improvement and patient safety, including the reduction of medical errors, is defined, implemented, and maintained;

9.1.4.1.2. That the Hospital-wide quality assessment and performance improvement efforts address priorities for improved quality of care and patient safety; and that all improvement actions are evaluated;

9.1.4.1.3. That clear expectations for safety are established;

9.1.4.1.4. That adequate resources are allocated for measuring, assessing, improving, and sustaining the Hospital's performance and reducing risk to patients; and,

9.1.4.1.5. That the Medical Staff participate in any determination by Administration as to distinct improvement projects to be conducted annually.

9.1.4.2. Medical Staff Leadership Role in Performance Improvement:
The Medical Staff shall perform a leadership role in the

²⁰³ 42 C.F.R. §482.21(a)(1)

²⁰⁴ 42 C.F.R §482.22(a)(1), 42 C.F.R. §482.22(c)(3), Survey Procedures

²⁰⁵ MS.05.01.03

²⁰⁶ 42 C.F.R. §482.21

Hospital's quality assessment, performance improvement, and patient safety activities when the performance of a process is dependent primarily on the activities of one or more individuals with clinical privileges and as more specifically delineated in Section 9.4.13 and 9.7 of these Bylaws.²⁰⁷ Such activities shall include, but are not limited to a review of the following:

- 9.1.4.2.1. Use of patient safety data, proactive risk assessment and risk reduction activities, and implementation of procedures to respond to patient safety alerts and comply with patient safety goals;²⁰⁸
- 9.1.4.2.2. Root cause analysis, investigation and response to any unanticipated adverse events;²⁰⁹
- 9.1.4.2.3. Medical assessment and treatment of patients, including a review of all medical and surgical services for the appropriateness of diagnosis and treatment;²¹⁰
- 9.1.4.2.4. Review and analysis of performance based on the results of core measures;
- 9.1.4.2.5. Use of information about adverse privileging decisions for any Practitioner privileged through the medical staff process;²¹¹
- 9.1.4.2.6. Use of medications, including the review of any significant adverse drug reactions or medication errors, and the use of experimental drugs and procedures;²¹²
- 9.1.4.2.7. Use of blood and blood components, including the review of any significant transfusions reactions;²¹³
- 9.1.4.2.8. Use of operative and other procedures, including tissue review and the review of any major

²⁰⁷ MS.05.01.01; 59A-3.271, F.A.C.

²⁰⁸ LD.04.04.05; MS.05.01.01

²⁰⁹ LD.04.04.05; MS.05.01.01

²¹⁰ MS.05.01.01; PI.01.01.01; MM.08.01.01; PC.03.02.11; PC.03.03.31; 42 C.F.R. §482.21(a)(3)

²¹¹ MS.05.01.01

²¹² MS.05.01.01; PI.01.01.01; MM.08.01.01; PC.03.02.11; PC.03.03.31; 42 C.F.R. §482.21; 42 C.F.R. §482.23(c)(4); 42 C.F.R. §482.25(b)(6)

²¹³ MS.05.01.01; PI.01.01.01; MM.08.01.01; PC.03.02.11; PC.03.03.31; 42 C.F.R. §482.21

discrepancy between pre-operative and post-operative (including pathological) diagnoses;²¹⁴

9.1.4.2.9. Review of appropriateness, medical necessity, and efficiency of clinical practice patterns, including, but not limited to, the review of surgical appropriateness, readmissions, appropriateness of discharge, and resource/utilization review;²¹⁵

9.1.4.2.10. Significant departures from established patterns of clinical practice including, but not limited to, review of any sentinel events, risk management reports and patient or staff complaints involving the Medical Staff;²¹⁶

9.1.4.2.11. Use of developed criteria for autopsies;²¹⁷

9.1.4.2.12. Recommend to the Board policies and procedures which define the circumstances, trends, indications, deviated expectations or outcomes, or concerns that trigger a focused review of a practitioner's performance and evaluation of a practitioner's performance by peers; and²¹⁸

9.1.4.2.13. Make recommendations to the MEC and Unified Medical Staff Council subject to Board approval regarding the types and amounts of data to be collected and evaluated to allow the Medical Staff to conduct an evidence-based analysis of the quality of professional practice of its members; and receive regular reports from department subcommittees regarding all pertinent recommendations and actions by the subcommittees.²¹⁹

9.1.4.3. Medical Staff Participant Role in Performance Improvement: The Medical Staff shall participate in the measurement, assessment, and improvement of other patient care processes.²²⁰ Such activities shall include, but are not limited to a review of the following:

²¹⁴ MS.05.01.01; PI.01.01.01; MM.08.01.01; PC.03.02.11; PC.03.03.31; 42 C.F.R. §482.21

²¹⁵ MS.05.01.01; 42 C.F.R. §482.21; 42 C.F.R. §482.30

²¹⁶ MS.05.01.01; 42 C.F.R. §482.21

²¹⁷ MS.05.01.01

²¹⁸ MS.08.01.01

²¹⁹ MS.08.01.01;

²²⁰ MS.05.01.03

- 9.1.4.3.1. Analyzing and improving patient satisfaction;²²¹
- 9.1.4.3.2. Education of patients and families;²²²
- 9.1.4.3.3. Coordination of care with other practitioners and hospital personnel, as relevant to the care of an individual patient;²²³
- 9.1.4.3.4. Accurate, timely, and legible completion of patients' medical records, including a review of medical record delinquency rates;²²⁴
- 9.1.4.3.5. The quality and content of history and physical exams;²²⁵
- 9.1.4.3.6. Surveillance of nosocomial infections; and,²²⁶
- 9.1.4.3.7. Make annual recommendations to the Board concerning peer review procedures.²²⁷

9.1.4.4. Medical Staff Peer Review: When the findings of quality assessment or performance improvement activities as outlined in this Section 9.1.4 are deemed relevant to an individual's performance or competence and the individual is a Medical Staff member or holds clinical privileges, the Medical Staff is responsible for determining the use of such findings in carrying out its quality/peer review functions in accordance with these Bylaws.²²⁸

9.1.5. CONTINUING MEDICAL EDUCATION

Since the Medical Staff recognizes continuing education as an adjunct to maintaining clinical skills and current competence, all individuals with clinical privileges shall participate in continuing education.²²⁹ In supporting high quality patient care, the Hospital and the Medical Staff shall sponsor educational activities that are consistent with Broward Health's mission, the patient population served, and the patient care

²²¹ MS.03.01.01

²²² MS.05.01.03

²²³ MS.05.01.03

²²⁴ MS.05.01.03; IM.02.02.01; IM.02.02.03; IM.04.01.01; 42 C.F.R. §482.21

²²⁵ MS.03.01.01

²²⁶ IC.01.03.01; 42 C.F.R. §482.21(a)(2); 42 C.F.R. §482.42(b)(1 – 2)

²²⁷ §395.0193(2)(f), F.S

²²⁸ MS.05.01.03; 42 C.F.R. §482.22(a)(1); §395.0193(2), F.S.

²²⁹ MS.12.01.01

services provided, within the limitations of applicable Federal laws and Broward Health policy and related to the findings of performance improvement activities.²³⁰

The Medical Staff may support affiliated professional graduate medical education programs by developing and upholding rules and regulations and policies within the framework of the organized Medical Staffs to provide for teaching and supervision by members of the Medical Staff of house staff members in carrying out their patient care responsibilities as set forth and developed in Medical Staff approved GME programs.²³¹

9.1.6. BYLAWS REVIEW AND REVISION

The Medical Staff shall provide a mechanism for adopting and amending the Medical Staff Bylaws, Rules and Regulations, and Medical Staff approved policies and for reviewing and revising same as necessary to:

9.1.6.1. Remain in compliance with all applicable Federal and State laws and regulations, and applicable accreditation standards;²³²

9.1.6.2. Remain current with the Medical Staff's organization, structure, functions, responsibilities and accountabilities;²³³ and,

9.1.6.3. Remain consistent with Medical Staff approved policies.²³⁴

9.1.6.4. Remain consistent with the Bylaws of the Board in effect at the time of adoption of these Bylaws or such amendments thereto undertaken as required to comply with all applicable Federal and State laws and regulations, and applicable accreditation standards.

9.1.7. NOMINATING

The Medical Staff shall establish a process as set forth in these Bylaws, with the support of the Administration, for selecting qualified officers to give leadership to the Medical Staff organization.²³⁵

9.2. PRINCIPLES GOVERNING COMMITTEES

²³⁰ MS.12.01.01

²³¹ MS.04.01.01

²³² LD.04.01.01

²³³ LD.01.05.01; MS.01.01.01

²³⁴ LD.01.03.01; LD.02.04.01; LD.03.02.01; LD.03.04.01; LD.03.05.01; LD.03.06.01

²³⁵ MS.01.01.01

The key functions of the Medical Staff shall be performed ongoing through the activities of the Departments, Sections, and committees of the Medical Staff. Specific key functions of the Medical Staff in the performance of credentialing, quality assessment and performance improvement, peer review and continuing and graduate medical education shall be performed through Medical Staff mandated committees performing such key functions and each Medical Staff shall insure the establishment and performance of such key functions. The Medical Executive Committee may recommend to the Board the addition, deletion or modification of any standing committee of the Medical Staff with the exception of the Medical Executive Committee. Such recommendations will be enacted following approval by the Board. In addition to the mandated committees, the Medical Executive Committee or the Chief of Staff may designate a subcommittee of any mandated committee or a special committee. The composition, duties and authority, and procedures for meetings and reporting of any subcommittee or special committee shall be specified in written policies or plans that are approved by the Medical Executive Committee. The continued need for a subcommittee or special committee shall be evaluated when the policy or plan that specifies the function of the committee is due for appraisal, which shall be at least every three years. If continued need for the subcommittee or special committee is no longer present, the subcommittee or special committee may be abolished by affirmative action of the Medical Executive Committee.

9.3. DESIGNATION

The current mandated committees of the Medical Staff are the Medical Executive Committee, the Credentials and Qualifications Committee, the Quality/Peer Review Committees, the Medical Education Committee, the Bylaws Committee, the Nominating Committees, the Pharmacy and Therapeutics Committee, the Bioethics Committee, and the Health Technology Committee.

9.4. OPERATIONAL MATTERS RELATING TO COMMITTEES

9.4.1. REPRESENTATION ON HOSPITAL COMMITTEES

In addition to the Medical Staff committees provided for in this Article, the leaders of the Medical Staff shall collaborate with other Hospital leaders in planning for the performance of certain interdisciplinary functions through the establishment of Hospital committees. When a Hospital committee shall be involved in deliberations affecting those matters for which the Medical Staff is responsible as provided by these Bylaws, any such Hospital committee shall include Medical Staff representation and participation.²³⁶ Medical Staff representatives for a Hospital committee shall be appointed by the Chief of Staff upon consultation with the Chief Executive Officer.

²³⁶ LD.01.05.01; MS.01.01.01; MS.01.01.03; MS.02.01.01; MS.10.01.01

9.4.2. EX-OFFICIO MEMBERS

The Chief Executive Officer shall be a non-voting ex-officio member of all Medical Staff committees. The Chief Executive Officer may designate another senior administrative member to attend any meeting in his/her place. Other ex-officio members of specific standing committees shall be defined in the committee composition for each committee.²³⁷

9.4.3. APPOINTMENT OF CHAIRPERSON AND MEMBERS

Prior to the end of each Medical Staff year, the MEC shall appoint Medical Staff members to Medical Staff standing committee positions due to be vacated at the start of the next Medical Staff year. Terms of appointment shall commence at the start of the next Medical Staff year. Appointment of the chairpersons and any appointed members of the Medical Executive Committee, Credentials and Qualifications Committee, Quality/Peer Review Committee and any other committee performing a professional review activity shall be subject to ratification by the Board per Article VII, Section 7.3.3 of these Bylaws. The Chief Executive Officer, in consultation and with the approval of the Chief of Staff, may make administrative staff appointments to a Medical Staff committee. Administrative staff members serving on a Medical Staff committee shall not have the right to vote.

9.4.4. TERM, PRIOR REMOVAL AND VACANCIES

Unless specified otherwise, the term of office for a Medical Staff committee chairperson or committee member shall be two (2) years. To promote continuity, The MEC will endeavor to appoint approximately one half of the committee membership appointments to commence on the first day of odd-numbered Medical Staff years, and the other half to commence on even-numbered years.

If a chairperson or member of a committee fails to maintain Medical Staff membership in good standing or fails to attend, participate or perform the duties of the committee position, the Medical Executive Committee may remove that member from the committee position. As a condition of serving on a committee, and by virtue of having accepted the appointment, each member agrees to participate on the committee and further agrees not to divulge any of the peer review or other confidential proceedings of the committee. Failure to abide by the confidentiality requirements for such proceedings shall subject the member to removal from the committee and possible corrective actions, as warranted. Unless otherwise specifically provided, vacancies on any

²³⁷ MS.02.01.01

committee shall be filled in the same manner in which an original appointment to such committee is made.²³⁸

9.4.5. NOTICE

Notice of a committee meeting may be given in the same manner as notice for Medical Staff meetings, but in addition, notice for a committee meeting may be given orally and where practically possible such notice should be given not less than three (3) days before the meeting.

9.4.6. MEETINGS

The frequency of meetings shall be defined in writing for each committee, and shall be appropriate to the duties and functions of the committee unless stated elsewhere in the Bylaws or applicable rules and regulations. All business meetings for all committees, subcommittees, Departments, and Sections generally shall be held on the Broward Health campus, unless another location is approved by the MEC for a particular meeting.

9.4.7. QUORUM

A majority of the voting members of a committee present in person, or by interactive telecommunications, at a meeting shall constitute a quorum of the committee, except as otherwise provided in Section 10.6.2 with respect to Departmental and Section meetings.

9.4.8. MANNER OF ACTING

The act of a majority of the voting members of a committee present at a meeting at which a quorum is present shall be the act of the committee. No action of a committee shall be valid unless taken at a meeting at which a quorum is present; however, any action, which may be taken at a meeting, may be taken without a meeting if consent in writing, setting forth the action, is signed by a majority of the members of the committee entitled to vote.

9.4.9. ACTION THROUGH SUBCOMMITTEES

Unless specifically delegated in a subcommittee's written scope of authority, a subcommittee shall not take any action that requires the vote of the committee to which it reports. The subcommittee shall submit recommendations, to be acted on by the committee to which it reports.

9.4.10. MINUTES

²³⁸ §395.0193(7)(8), F.S.

Each committee and subcommittee shall record minutes of each meeting in a format consistent with then current practice of the applicable Hospital, recorded in English. The minutes shall record the date and time of the meeting, the names of those attending the meeting, the items of business brought before the committee or subcommittee, and the committee's or subcommittee's conclusions, recommendations, actions and plans for follow-up. A copy of all meeting minutes, and all reports, records or other materials of each committee shall be kept and maintained in the Hospital for at least the current year plus three (3) years, after which they may be placed in archive storage, for such period of time as required by law or for perpetuity.

9.4.11. PROCEDURES

Each committee may formally or informally adopt its own rules of procedure, which shall not be inconsistent with the terms of its creation or these Bylaws.

9.4.12. REPORTS

Each mandated and special committee of the Medical Staff shall periodically report its activities, findings, conclusions, recommendations, actions, and results of actions to the Medical Executive Committee. Each subcommittee shall periodically report its activities to the committee of which it is a part or otherwise reports.

9.4.13. COMMITTEES, DEPARTMENTS AND SECTIONS WITH PEER REVIEW RESPONSIBILITIES

9.4.13.1 Peer review is the concurrent or retrospective review of the professional qualifications, professional competence, or professional conduct, including through clinical professional review activities of an individual who holds Medical Staff membership or privileges pursuant to these Bylaws. Peer review, also referred to as professional review activity, is conducted to determine whether an individual shall be granted Medical Staff membership or clinical privileges, to determine the scope and conditions of such membership or privileges, or to change or modify such membership or privileges.²³⁹ A peer review process includes any process, program or proceeding involving any or all of the following Hospital committees or functions: patient safety, performance improvement, utilization management, credentialing, infection control, review of use of operative and invasive procedures, review of medical records,

²³⁹ 42 USC §111135; 42 C.F.R. §482.21(c); 42 C.F.R. §482.22(a)(1), §395.0193, F.S.

review of use of medications, review of use of blood and blood components, clinical risk management, quality assessment, any other review or investigation of professional performance or conduct of a member of Medical Staff or individual who otherwise holds clinical privileges, and fair hearings conducted pursuant to Article 6 of these Bylaws.

9.4.13.2. Purpose of Peer Review: The peer review processes, programs, and proceedings are to encourage candid discussions and evidence based review and analysis with the primary purpose of peer review activities being to improve an individual's performance. Peer review analysis should be undertaken whenever: data comparisons indicate that the level of an individual's performance patterns or trends vary substantially from the expected;²⁴⁰ for unanticipated adverse events when root cause analysis indicates human factors related to an individual's performance are possibly significant to the cause of the event.²⁴¹ Peer review may be conducted for other reasons including, but not limited to, situations involving an individual case that may fall outside the standard of care, failure to comply with these Bylaws, Medical Staff Rules and Regulations or Medical Staff approved policies, adverse reports or other reliable information received or made available from outside entities regarding quality of care, or in any other circumstance deemed necessary by the Chief of Staff, Medical Executive Committee, or any other committee authorized to review or evaluate an individual's performance, or the CEO. An external reviewer or review panel may be used when the Medical Staff lacks necessary expertise, when there is a question of conflict of interest, when additional review is needed to confirm peer review results, or in any other circumstance in which external review is deemed necessary by the Chief of Staff, CEO, Medical Executive Committee or such other committee authorized to review or evaluate an individual's performance.²⁴²

9.4.13.3. Peer Review Information: All peer review information shall be kept private and confidential, including an individual Practitioner's peer review file. A Practitioner, other individual with clinical privileges, or other Hospital staff member who participates or has participated in a peer review process at the Hospital shall treat all peer review information obtained, generated or compiled as private, confidential and privileged

²⁴⁰ PI.01.01.01; PI.02.01.01

²⁴¹ PI.01.01.01; PI.02.01.01

²⁴² MS.08.01.01; MS.08.01.03; MS.09.01.01

and shall not disclose any such peer review information unless required by law.

- 9.4.13.4. Peer Review Panel: Professional review shall be conducted by a professional review body (e.g., a committee with a designated peer review function or an ad hoc peer review panel), any person acting as a member or staff to a professional review body, or any person under contract with a professional review body.²⁴³ Ad hoc peer review panels may be selected for specific focused review by the Chief of Staff or the MEC as authorized by these Bylaws or otherwise at the direction of the MEC.²⁴⁴
- 9.4.13.5. Timeframes for Review: Focused peer review activities shall be conducted in a timely fashion by the appropriate committee and the results reported within 90 days from completion of the focused review. In circumstances requiring ongoing review before a determination can be made, an interim report may be submitted within the defined timeframe if the final report will not be completed within the defined timeframe.²⁴⁵
- 9.4.13.6 Participation in Review: The individual whose performance or conduct is being reviewed shall have an opportunity to participate in the peer review process, either through attendance at a meeting in which the peer review results are discussed, in interviews with peer reviewer as determined by the peer reviewers, or any other form of communication or correspondence with peer reviewers or the peer review panel. If the individual has been offered an opportunity to participate but the individual decides not to participate, the review may be concluded and final results reported without the participation of the individual.²⁴⁶
- 9.4.13.7. Records and Minutes: The records and minutes of Medical Staff meetings and other Hospital committees and functions engaged in peer review shall be considered confidential, unless otherwise provided by law. The commencement and completion of a peer review process will be documented; peer review processes that are continuous and ongoing will be identified. Peer review records and information will be identified with a conspicuous notation or stamp, for example: CONFIDENTIAL PEER REVIEW INFORMATION.

²⁴³ HCQIA §11111(a)(1)(A-C)

²⁴⁴ MS.08.01.01; MS.08.01.03; MS.09.01.01

²⁴⁵ MS.08.01.01; MS.08.01.03; MS.09.01.01

²⁴⁶ MS.08.01.01; MS.08.01.03; MS.09.01.01

9.4.13.8. Credentialing Records: The credentialing record or file of each Practitioner or other individual with clinical privileges shall be subject to the peer review privilege and maintained separately and identified as peer review information.

9.4.13.9. Custody and Access: Peer review records, including Medical Staff records, are within the custody of the Hospital and maintained in the Medical Staff office at each applicable Hospital for the period of time required by law.

9.4.13.9.1. A Practitioner or other individual with clinical privileges shall be permitted to review his or her quality file during business hours at the Medical Staff office, upon request and sufficient time for the Medical Staff Office personnel to arrange for such review, which shall be monitored by such personnel. No copies or imaging of such file may be made for the requesting individual or any other third party.

A request by a Practitioner or other individual with clinical privileges to access his or her peer review file or peer review information concerning an investigation of which she or he is the subject shall be made by written request to the Medical Staff Office and shall be granted by the Chief Executive Officer, or his or her designee, in consultation with the Chief of Staff and legal counsel for the Medical Staff, only upon a finding that the individual has a compelling need for such information. Such a finding and corresponding grant of permission shall be in writing and maintained in the requesting individual's peer review file.

A request by a Practitioner or other individual with clinical privileges to access his or her credentials or other Medical Staff maintained file for the individual Practitioner shall be made by written request to the Medical Staff Office and shall be granted by the MEC, upon consultation with legal counsel for the Medical Staff, only upon a finding that the individual has a compelling need for such information. Such a finding and corresponding grant of permission shall be in writing and maintained in the requesting individual's credentialing file in writing and permitted Factors

to be considered include the reasons for which access is requested; whether the release of information might have an adverse effect on the Hospital, the Medical Staff, the individual or other persons; whether the information could be obtained in a less intrusive manner; whether the information was provided to the Hospital in specific reliance upon continued confidentiality; whether a harmful precedent might be established by the release; and such other factors as might be considered appropriate. The Medical Executive Committee may impose restrictions or conditions if access is permitted.

For purposes of this Section, peer review file and credentialing file shall include those records maintained by the Medical Staff office or such other peer review committee or quality assurance committee that are maintained with respect to an individual Practitioner or relate to an identified Practitioner for purposes of assessing that Practitioner's privileges, membership or grant of membership to Medical Staff or his or her ongoing delivery of medical care and fulfillment of his or her responsibilities under these Bylaws. None of the protections and processes provided in this Section 9.4 is intended to interfere with any rights of the Practitioner in the event of a Fair Hearing procedure as provided for in Article VI of these Bylaws.

9.4.13.10. The Chief Executive Officer, authorized Hospital staff members participating in utilization management functions, accreditation processes, legal compliance, or in performance improvement activities, may be afforded access to Medical Staff files and records, as required to comply with any governing law or regulation or in furtherance of the requesting party's collaborative efforts with the Medical Staff in carrying out Medical Staff functions and duties as provided in these Bylaws.. Medical Staff members who serve on Medical Staff committees may have access to the records of committees on which they serve and to the applicable credentials, peer review, utilization management, and performance improvement files of individuals whose qualifications or performance the committee is reviewing as part of its responsibilities and to the extent necessary to perform their responsibilities and official functions. Any such access shall

be documented in the particular file for which review is requested by indicating the date of such review, its purpose and the individual(s) or committee to which access was provided.

- 9.4.13.11. Outside Requests for Information: The Medical Staff Office and the Chief of Staff (or designee) may release information contained in Medical Staff records, including peer review information, quality or credentialing files in response to a proper request from a professional review body of another hospital or health care facility or institution, provided that the request includes a representation that the information shall be kept confidential. The request must include information that the Practitioner or other individual with clinical privileges is a member of the requesting facility's medical staff or has been granted privileges at the requesting facility, or is an applicant for medical staff membership or clinical privileges at that facility, and must include a release for such records signed by the individual involved. No information shall be released until a copy of a signed authorization and release from liability has been received. Disclosure shall generally be limited to the specific information requested. By applying for membership and/or privileges, the Practitioner specifically authorizes this disclosure.
- 9.4.13.12. Reporting Obligations: If a Practitioner or other individual with clinical privileges has been the subject of disciplinary action at the Hospital and information concerning the action must be reported to the state professional licensing or regulatory authorities, appropriate information from Medical Staff files may be released for such reporting and compliance purposes.
- 9.4.13.13. Surveyor Review: Hospital surveyors from licensing and regulatory agencies and authorities and accreditation bodies may be given access to Medical Staff office records on the Hospital premises in the presence of Medical Staff office personnel in accordance with law or accreditation requirements, provided that (a) no originals or copies may be removed from the premises, except pursuant to court or administrative order or subpoena or accreditation or other legal requirements, (b) access is provided only with the concurrence of the Chief Executive Officer (or designee) and the Chief of Staff (or designee), and (c) the surveyor demonstrates the following to the satisfaction of the Chief Executive Officer or Chief of Staff:

- 9.4.13.13.1. Specific statutory, regulatory or other appropriate authority to review the requested materials;
 - 9.4.13.13.2. The materials sought are directly pertinent to the matter being surveyed, investigated or evaluated;
 - 9.4.13.13.3. The materials sought are the most direct and least intrusive means to accomplish the purpose;
 - 9.4.13.13.4. Sufficient specificity of documents has been given to allow for the production of individual documents without undue burden to the Hospital; and,
 - 9.4.13.13.5. If requests are made for documents with identifiers, the need for such identifiers is given and is determined to be appropriate, and information will be kept confidential to the maximum extent permitted by law.
- 9.4.13.14. Subpoenas: All subpoenas of Medical Staff records shall be referred to the Chief Executive Officer or designee, and notice given to the affected Practitioner unless prohibited by law.
- 9.4.13.15. Legal Counsel: Legal counsel to Broward Health shall have access to information in Medical Staff records, including quality, credentialing and peer review information, as authorized in Section 9.4.13.10 or in the event of pending or threatened litigation when such information is necessary for Broward Health to appropriately investigate or defend any such claim, notice of which shall be provided the Practitioner per Section 9.4.13.18. For any other request for access to information in Medical Staff records, including quality, credentialing and peer review information, legal counsel to Broward Health shall submit a written request to the MEC detailing the need and appropriateness for the requested information to the Medical Staff office with a copy to legal counsel for the Medical Staffs. Such request shall be reviewed by legal counsel for the Medical Staff and granted if appropriate by the Chief of Staff or MEC.
- 9.4.13.16. Other Requests: All other requests by persons or organizations for information contained in Medical Staff records shall be forwarded to the Chief Executive Officer, or his or her designee, and to legal counsel for the Medical Staffs, for evaluation and joint concurrence as to the appropriateness of such request. All public record requests,

as defined by Chapter 119, shall be forwarded to the Broward Health General Counsel and all claims of confidentiality as confirmed by these Bylaws and applicable law shall be asserted in response to any such request.

9.4.13.17. Peer Review Meetings: All peer review functions shall be performed only at meetings held on the premises of Broward Health with the exception of attorney client sessions which may be held off-premises if necessary to facilitate such communication.

9.4.13.18. Record of information requests of a Practitioner's credentialing and quality files: A record of any request for review or review conducted of a Practitioner's quality or credentialing file shall be maintained in the Practitioner's quality file, which shall reflect the date the request was made, the purpose, whether the file was reviewed and the date of such review. In the event legal counsel for Broward Health conducts a review in connection with threatened or pending litigation, the Practitioner shall be notified prior to any review and provided the name and contact information of the legal counsel conducting such review.

9.5. MEDICAL EXECUTIVE COMMITTEE

9.5.1. COMPOSITION

Each Hospital shall have a Medical Executive Committee whose voting members shall be the elected Medical Staff officers and Immediate Past Chief of Staff; the Chairperson of all Departments; and the Vice Chairperson of all Departments having an active membership greater than 20% of the total Active staff of the Hospital. The Chief Executive Officer shall serve as a non-voting ex-officio member of the Committee.

No Medical Staff member actively practicing in the Hospital is ineligible for membership on the Medical Executive Committee solely because of his/her professional discipline or specialty.²⁴⁷

The Chief of Staff shall preside over all meetings. In his/her absence, the Vice Chief of Staff shall act in his/her place. The Secretary-Treasurer shall keep complete and accurate minutes of all meetings and call meetings upon the order of the Chief of Staff. The Presiding Officer may, at his or her discretion, invite or exclude other members of the Medical Staff, Administration or other guests but in no event may the

²⁴⁷ MS.02.01.01

Presiding Officer exclude the CEO or his or her designee from any portion of the MEC meeting.

9.5.2. DUTIES AND AUTHORITY

The Medical Executive Committee is empowered to represent and act for the Medical Staff in the interval between Medical Staff meetings.²⁴⁸ The Medical Executive Committee shall perform or direct the performance of the duties relative to the key functions of Governance and Planning, as described in these Bylaws in Sections 9.1.1 and 9.1.2, and oversee the performance of other key functions. The following duties shall be performed by the Medical Executive Committee:

- 9.5.2.1. To represent the Medical Staff, to act on its behalf, to provide a liaison between the Medical Staff, the Hospital Administration and the Board of Commissioners with regard to policy decisions affecting patient care services;
- 9.5.2.2. To coordinate the activities of the separate clinical Departments; to review and approve any changes in the manner a Department handles its on-call obligations and to collaborate with the Administration and approve any exclusive or contractual call schedules of Department-wide application and to recommend action to the Chief Executive Officer on matters concerning medical care and long-range planning for medical facilities to the Board of Commissioners;
- 9.5.2.3. To establish policies for the maintenance of quality medical care and quality review processes and to assure compliance with the Bylaws and Rules and Regulations and to organize the Medical Staff's quality assessment and performance improvement activities and establishing a mechanism designed to conduct, evaluate and revise such activities;
- 9.5.2.4. To receive and act on reports and recommendations from Medical Staff committees, Departments, and assigned activity groups, specifically as related to Medical Staff quality assessment and performance improvement activities;²⁴⁹
- 9.5.2.5. To review the qualifications, evidence of current competence, and the recommendations of a Department Chairperson and the Credentials and Qualifications Committee for each individual applying for Medical Staff membership or clinical privileges, and make recommendations for appointment,

²⁴⁸ MS.02.01.01

²⁴⁹ MS.02.01.01

reappointment, staff category, assignment to Departments and Sections, clinical privileges, and any disciplinary actions;

- 9.5.2.6. To take all reasonable steps to ensure professionally ethical conduct on the part of all members of the Medical Staff and to initiate such prescribed corrective measures as are indicated;
- 9.5.2.7. To act on all temporary privileges in accordance with Section 4.3 of these Bylaws;
- 9.5.2.8. To resolve problems of discipline and privilege upon referral from the clinical Departments;
- 9.5.2.9. To review periodic reports on the status of the Hospital by the Chief Executive Officer;
- 9.5.2.10. To approve and direct the disbursement of Medical Staff funds by the Secretary-Treasurer;
- 9.5.2.11. To coordinate the Medical Staff aspects of accreditation;
- 9.5.2.12. To report at each Medical Staff meeting with regard to the actions taken by the Medical Executive Committee on behalf of the Medical Staff;
- 9.5.2.13. To provide for current Medical Staff Bylaws, rules and regulations, and Medical Staff policies, subject to the approval of the Board;
- 9.5.2.14. To collaborate with other leaders of the organization in Hospital planning;
- 9.5.2.15. To conduct and supervise Medical Staff peer review activities;

9.5.3. MEETINGS AND REPORTING

The Medical Executive Committee shall meet monthly, not less than ten (10) times per year, and at such other times deemed necessary by the Chief of Staff, CEO or by a vote of at least one-half of the Medical Executive Committee voting members. A quorum for all meetings shall be a majority of the voting members of the Committee.

9.6. CREDENTIALS AND QUALIFICATIONS COMMITTEE

9.6.1. COMPOSITION

The Credentials and Qualifications Committee shall be composed of at least nine (9) voting members in good standing. The voting membership shall include, except for provided elsewhere herein, the Vice Chief of Staff, the Vice Chairpersons of each of the Medical Staff Departments, and at least one other active staff member from each Department if the Vice Chair of said department is not a Member. In addition, the Chief Executive Officer shall serve as a non-voting ex-officio member of the Committee.

9.6.2. DUTIES AND AUTHORITY

The Credentials and Qualifications Committee shall perform the key functions of Credentialing, as described in these Bylaws in Section 9.1.3, under the oversight and direction of the Medical Executive Committee. In addition, the following specific functions shall be performed by the Credentials and Qualifications Committee:

- 9.6.2.1. Oversee a mechanism to ensure that all Medical Staff members and individuals with clinical privileges maintain required credentials ongoing;²⁵⁰
- 9.6.2.2. Through making recommendations related to granting clinical privileges, ensure that the same level of quality of care is provided by all individuals with delineated clinical privileges, within Medical Staff Departments, across Departments, and between members and non-members of the Medical Staff who have delineated clinical privileges;²⁵¹
- 9.6.2.3. Oversee a mechanism to ensure that the scope of practice of individuals with clinical privileges is limited to the clinical privileges granted;²⁵²
- 9.6.2.4. Make recommendations to the Medical Executive Committee with regard to any revisions in the process for appointment, reappointment or delineation of clinical privileges.

9.6.3 MEETINGS AND REPORTING

The Credentials and Qualifications Committee shall meet monthly, not less than ten (10) times per year, and at such other times deemed necessary by the Chief of Staff, the CEO or by vote of at least one-half of the committee members and shall report their recommendations and

²⁵⁰ MS.02.01.01; MS.06.01.03; MS.06.01.07; MS.08.01.03

²⁵¹ LD.02.01.01; LD.03.02.01; LD.03.03.01; LD.04.03.01; LD.01.05.01

²⁵² MS.08.01.03

activities to the MEC. A quorum for all meetings shall be a majority of the voting members of the Committee.

9.7. QUALITY/PEER REVIEW COMMITTEE

9.7.1. COMPOSITION

Each Department within the hospital shall have a Quality/Peer Review Committee or shall combine such quality/peer review duties and responsibilities within a joint or combined committee for multiple departments of the Hospital. Each Quality/Peer Review Committee shall be composed of at least five (5) voting members in good standing. The Chief Executive Officer, or his or her designee, shall serve as an ex-officio member of the Committee. The Quality/Peer Review Committee shall also have the option of calling upon any member of the Medical Staff to serve on the committee on an ad hoc basis to provide clinical review and recommendations to the committee, their appointment subject to the approval of the Chief of Staff acting on behalf of the Medical Executive Committee, the Chief Executive Officer, and the Board in this singular capacity. Ad hoc members of the committee shall be bound by the confidentiality requirements of the committee and shall be provided indemnification while serving on the committee, subject to the provisions of Article VII. Ad hoc members of the committee shall not have voting rights on the committee.

9.7.2. DUTIES AND AUTHORITY

The Quality/Peer Review Committee shall perform the key function of Quality Assessment/Performance Improvement, as defined in these Bylaws in Section 9.1.4.3, 9.1.4.4, 9.4.13 and 9.7.²⁵³ In addition, the Quality/Peer Review Committee shall perform the following specific functions:

- 9.7.2.1. Participate in an annual evaluation of the Hospital's Performance Improvement program and in the development or revisions to the Performance Improvement Plan, including making recommendations for the establishment of priorities for the program;²⁵⁴ and,
- 9.7.2.2. Ensure that Medical Staff quality assessment and performance improvement activities address applicable review requirements found in regulatory and accreditation laws, regulations, and standards. Also, ensure that the activities address the scope of patient care provided and are effective

²⁵³ MS.05.01.03; 42 C.F.R. §482.22(a)(1)

²⁵⁴ PI.03.01.01; LD.03.03.01; LD.03.05.01; LD.04.04.01

by reviewing the reports of the Medical Staff Departments and any other Medical Staff or Hospital quality review groups and making recommendations to the Medical Executive Committee.

9.8. MEDICAL EDUCATION COMMITTEE

9.8.1. COMPOSITION

The Medical Education Committee shall be composed of voting members in good standing as appointed by the Chief of Staff and approved by the MEC.

9.8.2. DUTIES AND AUTHORITY

The Medical Education Committee shall perform the key functions of Continuing Medical Education, as described in these Bylaws in Section 9.1.5, under the oversight and direction of the Medical Executive Committee.

The Medical Education Committee shall further endeavor to promote undergraduate and graduate educational programs in accordance with Affiliation Agreements between Broward Health and the applicable educational institution and approved by the MEC with respect to any teaching program within the Hospital.

9.9. BYLAWS COMMITTEE

9.9.1. COMPOSITION

The Bylaws Committee shall be a Broward Health system-wide committee comprised of representatives from all of the Hospitals. The composition of the voting members shall be three representatives from each Hospital, one being a voting member of the MEC and two additional members appointed by the MEC. Legal Counsel for the Medical Staffs shall serve as an ex-officio member of the Committee. The Chief Executive Officer in conjunction with his or her Administrative delegate shall provide a quarterly report to the Bylaws Committee of any new or emerging regulatory or legal requirements that impact Medical Staff governance for consideration by the Committee.

9.9.2. DUTIES AND AUTHORITY

The Bylaws Committee shall perform the key function of Bylaws Review and Revision, as described in these Bylaws in Section 9.1.6, under the oversight and direction of the Unified Medical Staff Committee. The Bylaws Committee shall review these Bylaws, the Rules and

Regulations and Medical Staff approved policies and initiatives, as applicable, and recommend any needed additions, revisions, modifications, amendments or deletions. The Bylaws Committee shall also review all Department rules and regulations.

9.9.3. MEETINGS AND REPORTING

The Bylaws Committee shall meet at least quarterly in coordination with the meeting schedule of the Unified Medical Staff Committee, and shall report their recommendations and activities to the Unified Medical Staff Committee.²⁵⁵ The location for such meetings shall rotate between each Hospital.

9.10. NOMINATING COMMITTEES

9.10.1. COMPOSITION

9.10.1.1. NOMINATING COMMITTEE FOR MEDICAL STAFF OFFICERS

The Nominating Committee for Medical Staff officers shall be voting members composed of current Chief of Staff and the two most recent Chiefs of Staff. The Immediate Past Chief of Staff shall serve as Chair. If the two most recent Past Chiefs of Staff are not available, the current Chief of Staff may appoint additional members to replace that membership position who are then currently serving as a Departmental Officer. If requested by the Chair, Legal Counsel for the Medical Staffs shall serve as an ex-officio member.

9.10.1.2. NOMINATING COMMITTEE FOR DEPARTMENTAL OFFICERS

The Nominating Committee for Departmental Officers shall be voting members composed of the current Department Chairperson, and the two most recent Department Chairpersons. If any designated member is unavailable to serve or disqualified by virtue of his or her intended candidacy for a departmental office, the current Chairperson shall appoint a member from the Department as a replacement. No candidate for election may serve as a member of the Departmental Nominating Committee.

9.10.2. DUTIES AND AUTHORITY

²⁵⁵ MS.02.01.01

The Nominating Committees shall perform the key functions of Nominating, as described in these Bylaws in Section 9.1.7, under the oversight and direction of the Medical Executive Committee. The Nominating Committee shall solicit and accept nominations for elected Medical Staff officer positions, consult with the nominees concerning their qualifications and willingness to serve.

9.10.3. MEETINGS AND REPORTING

The Nominating Committees shall meet when requested by the MEC and shall report their recommendations and activities to the MEC

9.11. PHARMACY & THERAPEUTICS COMMITTEE

9.11.1. COMPOSITION

The Pharmacy & Therapeutics Committee shall be composed of members in good standing. The voting membership shall be appointed by the chief of Staff, except for provided elsewhere herein, of at least three (3), but no more than ten (10), members in good standing who broadly represent the services of the Medical staff. Ex-officio members without voting privileges shall include the Chief Executive Officer, Chief Operating Officer, Chief Nursing Officer or designee, Director/Manager of Pharmacy, Director/Manager of Quality Management, Clinical Pharmacy Coordinator, Infection Control Coordinator, Chief Dietitian, Clinical Nutritionist and patient focused care pharmacists. Other ex-officio members and specialty-specific members shall be delineated in Medical Staff approved policies.²⁵⁶

Individuals shall disclose any conflict of interest, as defined by these Bylaws in accordance with Section 12.5.6 in connection with his or her participation in this Committee.

9.11.2. DUTIES AND AUTHORITY

The Pharmacy & Therapeutics Committee shall perform the following specific duties:

9.11.2.1. Assist in formulating broad professional policies regarding the medication and diagnostic testing material usage, evaluation, selection, procurement, distribution, handling use, safety procedures, and other matters relating to drugs in the hospital;²⁵⁷

²⁵⁶ MM.02.01.01; EM.02.02.03

²⁵⁷ MM.04.01.01

- 9.11.2.2. Develop a process to define, identify, and review significant adverse drug reactions for appropriate management and report significant or serious reactions to the FDA through the Med Watch Program;²⁵⁸
- 9.11.2.3. Develop a process to define, identify, and review significant medication errors;²⁵⁹
- 9.11.2.4. Advise the medical staff and hospital administration on matters pertaining to the choice of drugs;
- 9.11.2.5. Add to and delete from the formulary list of drugs accepted for use in the hospital;
- 9.11.2.6. Prevent unnecessary duplication in the stock of the same therapeutic drug and its preparation;
- 9.11.2.7. Develop a process for reviewing medication use that crosses all departments and includes high volume, critical component, and high abuse drugs;²⁶⁰
- 9.11.2.8. Design a method to determine which staff members should be granted privileges to prescribe parenteral nutrition therapy and forward recommendation to the Credentials & Qualifications Committee;²⁶¹
- 9.11.2.9. Provide a periodic review of parenteral/enteral nutrition practices to insure quality patient care and compliance to accepted standards of care;
- 9.11.2.10. Provide a consistent approach to nutrition support in all aspects of parenteral and enteral feedings, specialty diets and supplements;
- 9.11.2.11. Provide an annual review of hospital diet manual and enteral formulary; and,
- 9.11.2.12. Review and discuss nutrition related topics and/or problems.

9.11.3. MEETINGS AND REPORTING

The Pharmacy & Therapeutics Committee shall meet at least monthly, no less than ten (10) times per year, and shall forward their

²⁵⁸ MM.05.01.17

²⁵⁹ MM.07.01.01; MM.07.01.03

²⁶⁰ MM.01.01.03

²⁶¹ MM.05.01.11

recommendations and activities to the Medical Executive Committee for approval.

9.12. BIOETHICS COMMITTEE

9.12.1. COMPOSITION

The Bioethics Committee shall be multi-disciplinary in nature. The committee shall be a Broward health wide committee and represent all of the hospitals of Broward Health, composed of physicians, psychologists, clergy, nurses, social workers, ethicists, administrators, risk managers, academicians/philosophers, community leaders, and the Broward Health General Counsel or designee.

9.12.2. DUTIES AND AUTHORITY

Broward Health recognizes the need for a multidisciplinary committee to develop policies, participate in education of the staff and community, and consult on ethical issues with the organization. Because patients and health care workers may be confronted with increasingly complex ethical issues, Broward Health establishes a proactive forum for patients, families, hospital staff, and community groups to study and address the moral and ethical issues arising from contemporary advances in medicine and technology.

The purpose of the Bioethics Committee is to fulfill the need for information and guidance in the ethics of health care decision-making. The responsibilities include:

- 9.12.2.1. To provide a forum in which health care practitioners and others may come together so that policies and decisions involving patient care can be developed based upon sound medical, ethical, and legal principles;
- 9.12.2.2. To serve as a recommending body for the Medical Staff, Administration, and Board of Commissioners for the development of guidelines regarding patient care issues and organizational ethics;
- 9.12.2.3. To act as a clearing house for the staff for information on ethical theory in articles, as well as current related medical and legal information;
- 9.12.2.4. To conduct programs of ongoing education for physicians, medical personnel, and the health care community;

- 9.12.2.5. To serve as a multi-disciplinary resource and consultative body for patients, families, and health care professionals; and,
- 9.12.2.6. To periodically review policies in order to ensure compliance with current statutes and judicial decisions.

9.12.3. MEETINGS AND REPORTING

The Bioethics Committee shall meet at least monthly, not less than ten (10) times per year, and shall forward their recommendations and activities to the Medical Executive Committee for approval.

9.13. HEALTH TECHNOLOGY COMMITTEE

9.13.1. COMPOSITION

The Health Technology Committee shall be one committee representing all of the Hospitals of Broward Health in connection with those technology matters that involve and impact the Members delivery of medical care. The voting membership of the Health Technology Committee shall be comprised of and appointed as follows: the Chief of Staff of each hospital and CEO shall jointly appoint three members from each hospital which may include any of the following: the Chief Operating Officer, the Chief Nursing Officer, the Chief Financial Officer. In addition, the Chief Information Officer and the Director of Quality and Performance Improvement shall be members. The Chief Executive Officer shall serve as an ex-officio member of the Committee. Other ex-officio members and specialty-specific members shall attend at the invitation of the Chair. The Chair shall be elected by the Medical Staff members of the Committee.

9.13.2. DUTIES AND AUTHORITY

The Health Technology Committee shall perform the following specific duties:

- 9.13.2.1. Ensure that the Medical Staff has input in the evaluation and selection of medical technology including equipment and implantable devices and systems that are utilized by the Medical Staff in the delivery of medical care by the Practitioner;
- 9.13.2.2. Provide a forum for medical staff members to suggest new technologies, foster innovation and collaboration in the development of health information technology and allow for insightful and comprehensive analysis;

- 9.13.2.3. Assess the quality, efficacy, and appropriateness of medical technology with which the Medical Staff interacts, utilizes or otherwise relies upon for the delivery of medical care and the application to current and future hospital services as well as the impact on patient care;
- 9.13.2.4. Help ensure that resources are allocated responsibly and effectively as they relate to selection of and investment in medical and health information technology;
- 9.13.2.5. Serve as a resource in developing the strategic plan for Broward Health in connection with such health information technology concerns.

9.13.3. MEETINGS AND REPORTING

The Health Technology Committee will meet monthly, not less than ten (10) times per year. Additional ad hoc meetings will be scheduled if necessary. This Committee shall forward their recommendations and activities to the Medical Executive Committee for approval.

9.14. UNIFIED MEDICAL STAFF COMMITTEE

9.14.1 COMPOSITION

The Unified Medical Staff Council shall be a system-wide Medical Staff mandated committee consisting of: the Chief of Staff, the Vice Chief of Staff, the Secretary-Treasurer, and Immediate Past Chief of Staff of each Broward Health hospital, all of whom, or their designee, shall be voting members. In the event any designated member is unavailable to serve, that member shall appoint a designee who shall be a current member of the MEC. Legal Counsel for the Medical Staffs shall serve in an ex-officio advisory capacity.

The Chairperson shall call and preside over all meetings. In his/her absence, the Vice Chairperson shall act in his/her place. The Secretary shall keep complete and accurate minutes of all meetings and call meetings upon the order of the Chairperson. The Chairperson, Vice Chairperson, and Secretary shall be Medical Staff members elected annually by the members of the Committee.

9.14.2. DUTIES AND AUTHORITY

The Unified Medical Staff Council shall provide Medical Staff oversight by ensuring system-wide compliance, standardization, amendment and application of Medical Staff Bylaws, Rules and Regulations, and hospital

and system-wide policies and procedures approved by the Medical Staffs.

9.14.3. MEETINGS AND REPORTING

The Unified Medical Staff Council shall meet no less than quarterly, and at such other times deemed necessary by members of the Committee, or by a vote of one-half of the Committee's voting members. A quorum for all meetings shall be one-half of the voting members of the Committee. The Unified Medical Staff Council shall make direct recommendations to the Joint Conference Committee.

9.15. JOINT CONFERENCE COMMITTEE

9.15.1. COMPOSITION

The Joint Conference Committee shall be a Medical Staff and Administration joint committee. The voting members shall be comprised of: the Chief of Staff, the Vice Chief of Staff, and the Secretary/Treasurer of each Broward Health Hospital; three members of the Board of Commissioners; the Chief Executive Officer of each Broward Health hospital and the President/Chief Executive Officer of Broward Health. The Chief Medical Officer shall be an ex-officio member of the Committee. The Chairpersonship shall alternate annually between a Board of Commissioners member and a Medical Staff member elected by the Medical Staff Members of the Committee. In the event a designated Medical Staff member is unavailable, the designated member may appoint a designee who shall be a current member of the applicable MEC as a voting member.

9.15.2. DUTIES AND AUTHORITY

The Joint Conference Committee shall conduct itself as a forum for discussion, collaboration and conflict resolution relating to matters of Broward Health and Hospital policy and practice, especially those matters pertaining to the delivery of efficient, effective and quality patient care and shall be a medico-administrative liaison among the Medical Staffs, the Governing Body and the Administration.

9.15.3. MEETINGS AND REPORTING

The Joint Conference Committee shall meet at least twice a year or at any additional time at the request of either the Chairperson of the Committee, the Chairperson of the Board of Commissioners, the President/Chief Executive Officer of Broward Health, any three members of the Committee, or when the decision of the Board of Commissioners

is contrary to a recommendation of any MEC or the Unified Medical Staff Committee.

The recommendations of the Joint Conference Committee shall at all times be subject to final approval by the Board of Commissioners, which approval shall not be unreasonably withheld. It is the intent of these Bylaws that the Joint Conference Committee shall at all times endeavor to carry out the general purposes of the Board and shall exercise its authority in such a manner as to assist the Board in its proper performance of its duties, as is consistent with the Bylaws of Broward Health and these Bylaws.

ARTICLE X.

MEETINGS OF THE MEDICAL STAFF AND DEPARTMENTS AND SECTIONS

10.1. MEDICAL STAFF YEAR

The Medical Staff year shall be the period from May 1 to April 30 of each year.

10.2. MEDICAL STAFF MEETINGS

10.2.1. THE ANNUAL GENERAL STAFF MEETING

10.2.1.1. Active Staff and Provisional members must attend the Annual General Staff Meeting at their designated primary facility.

10.2.1.2. The Annual General Staff Meeting of each hospital shall be in April. Officers shall be installed at this meeting, when appropriate, but will take office on May 1st.

10.2.1.3. Annual reports of Departments and committees shall be presented and may be discussed at this meeting.

10.2.2. SPECIAL MEETINGS

Special meetings of the Medical Staff may be called by the Chief of Staff and shall be called by the Chief of Staff at the request of the Medical Executive Committee, Board of Commissioners, or any twenty members of the active staff by written request to the Chief of Staff, to be held at such time and place as shall be designated in the notice of the meeting. No business shall be transacted at a special meeting, except as specified in the notice or as otherwise expressly provided in these Bylaws.

10.3. DEPARTMENT AND SECTION MEETINGS

10.3.1. REGULAR MEETINGS

The frequency of and attendance at Departmental meetings will be determined by Rules established by each Department of each Hospital as approved by the Medical Executive Committee of each Hospital. Each Department may establish attendance requirements for its meetings and compliance with such requirements may be identified as a criterion for initial and continued membership in that Department and such other enforcement powers as the Department may deem reasonable. The purpose of the meetings will be to transact the business and affairs of the Department. Discussions at each Departmental meeting shall be recorded in minutes in the manner set forth in Section 9.4.10. The Sections shall meet as often as necessary to perform Section functions.

10.3.2. SPECIAL MEETINGS

Special meetings may be called by the Chairperson and shall be called by the Chairperson at the request of Ten Percent (10%) of the Active members of the Department by written request; to be held at such time and place as shall be designated in the notice of the meeting.

10.4. ATTENDANCE REQUIREMENTS

10.4.1. GENERALLY

Active Staff and Provisional members of the Medical Staff shall be required to attend the Annual General Staff Meeting and such Departmental meetings as established by the Rules of the Department unless excused by the Department Chair.

10.5. MEETING PROCEDURES

10.5.1. NOTICE OF MEETINGS

Notice of the date, time and place of the Annual Medical Staff Meeting shall be posted on the Medical Staff bulletin board no less than 30 days prior to the meeting. Notice of other Medical Staff, Departmental or Section meetings shall be posted on the Medical Staff bulletin board no less than 7 days prior to the meeting. Notice of special meetings shall be posted on the Medical Staff bulletin board no less than 48 hours prior to the meeting. The Medical Staff office shall endeavor to also give notice of all meetings by electronic communication, with a copy of the Agenda or draft Agenda attached.

Except as otherwise provided in Article VI, Fair Hearing and Appellate Review Procedures, notice to a Medical Staff member or other individual with clinical privileges who is being required to attend a meeting for

quality/peer review purposes shall be considered proper and valid when a registered, return receipt letter is sent at least seven (7) days prior to the meeting.

10.6. QUORUM

10.6.1. GENERAL STAFF MEETINGS

At least one-third of the voting staff members present in person shall constitute a quorum for the transaction of business at any Medical Staff meeting, except if less than such a number is present, a majority of the active staff members present may adjourn the meeting from time to time without further notice until a quorum is present. Voting by proxy shall not be permitted.

10.6.2. DEPARTMENT OR SECTION MEETINGS

The members physically present who are entitled to vote at a duly noticed meeting shall constitute a quorum of the department or section for purposes of conducting the ordinary and routine business and affairs of said department or section and considering and voting upon items noticed for consideration in the agenda. The agenda will be provided to all voting members of the department or section at least one week prior to the meeting, the manner of distribution (electronic, facsimile or other means) determined by the applicable Medical Staff office and the agenda will be posted on the Physician's portal. The agenda will also contain a summary of the disposition of items voted on at the prior meeting.

Any action that amends the department or section's rules and regulations or is of major importance to the department or section shall require for approval a vote of at least one-third of the voting staff members and such proposed action shall be noticed in advance by agenda as provided above. Such vote may be conducted at a noticed meeting at which at least one-third of the voting staff members present in person are in attendance and quorum so established, or the vote may be taken by ballot in the event the one-third of the voting staff members' quorum is not obtained at the noticed meeting. For purposes of any vote taken by ballot at a department or section meeting, other than elections as provided in Article VII, balloting may be conducted by regular or electronic mail, or any combination thereof, as established and overseen by the officers of the department or section. Approval shall require a simple majority of the votes cast.

Items that have not been noticed for consideration on the agenda may be discussed but may not be voted on or otherwise be approved as

official Department business until such items are noticed on the agenda for the next upcoming meeting, as provided above. Voting by proxy shall not be permitted.

10.7. MANNER OF ACTION

The act of a simple majority of the voting members present at a general Medical Staff meeting at which a quorum is present shall be the act of the Medical Staff. The act of the simple majority of voting Department or Section members present at a Medical Staff Department or Section meeting at which a quorum is present shall be the act of the Department or Section.

10.8. VOTING RIGHTS

Medical Staff members and others have the right to vote as provided in these Bylaws and Medical Staff policies.

10.9. RIGHTS OF EX-OFFICIO MEMBERS

Persons serving under these Bylaws as ex-officio members of a Medical Staff body shall have all rights and privileges of regular members except they shall not be counted in determining the existence of a quorum, and they shall not have voting rights unless expressly provided. At the discretion of the Chair, the ex officio members may be excused to allow discussion among the voting members; however, under no circumstance may the Presiding Officer exclude the CEO or his or her representative attending in the CEO's absence from the meeting.

10.10. MINUTES

The Secretary-Treasurer shall prepare minutes of each meeting of the Medical Staff, which shall include a record of attendance and the vote taken on each matter. Minutes shall be signed by the Secretary-Treasurer, approved by the presiding officer, and maintained in a permanent file. Minutes shall be available for inspection by Medical Staff members and hospital Administration for any proper purpose, subject to any policies concerning confidentiality of records and information. Each Department Chairperson and each Section Chief shall ensure that minutes are prepared for their respective Department or Section meetings in accordance with Section 9.4.10.

10.11. PROCEDURAL RULES

The Chief of Staff, or in his/her absence, the Vice Chief of Staff, shall preside at general Medical Staff meetings. Meetings shall be conducted in accordance with an acceptable form of parliamentary procedure, such as Robert's Rules of Order, as may be modified by the Medical Staff.

ARTICLE XI.
CONFIDENTIALITY, IMMUNITY AND RELEASE

11.1. AUTHORIZATIONS AND CONDITIONS

Any applicant for Medical Staff membership or clinical privileges and every member of the Medical Staff or individual with clinical privileges agree that the provisions of this Article shall specifically control with regard to his/her relationship to the Medical Staff, other members of Staff, members of the Board, and the Hospital. By submitting an application for membership or clinical privileges, by accepting appointment or reappointment to the Staff or clinical privileges, or by exercising clinical privileges including temporary privileges, each individual specifically agrees to be bound by these Bylaws, including the provisions of this Article during the processing of his/her application and at any time thereafter, and such provisions shall continue to apply during his/her term of membership or term of clinical privileges.

11.2. CONFIDENTIALITY OF INFORMATION

Any act, communication, report, recommendation or disclosure concerning any applicant for membership or clinical privileges given or made by anyone in good faith and without malice, with or without the request of any authorized representative of the Medical Staff, the Administration, the Board, the Hospital or any other healthcare facility or provider for the purposes of providing, achieving or maintaining quality patient care and hospital operations in the Hospital or at any other healthcare facility shall be confidential and protected from discovery to the fullest extent permitted by law. Such protection shall extend to members of the Medical Staff, the Chief Executive Officer, Administrative officials, Board members and their representatives and to third parties who furnish information to any of them to receive, release or act upon such information. Third parties shall include individuals, firms, corporations and other groups, entities, or associations from whom information has been requested or to whom information has been given by a member of the Medical Staff, authorized representatives of the Staff, the Administration, or the Board.

11.3. BREACH OF CONFIDENTIALITY

Inasmuch as effective peer review, credentialing and quality assessment/performance improvement activities must be based on free and candid discussions, any breach of confidentiality of the discussions, deliberations, or records of any Medical Staff meeting, Department, Section, or committee is outside appropriate standards of conduct for this Medical Staff and shall be deemed disruptive to the operation of the Hospital and as having an adverse impact on the quality of patient care. Such breach or threatened breach shall subject the individual responsible for a breach of confidentiality to

disciplinary action under the Medical Staff Bylaws, Rules and Regulations, and applicable Hospital policies.

11.4. IMMUNITY FROM LIABILITY AND INDEMNIFICATION

There shall, to the fullest extent permitted by law, and as otherwise confirmed in Section 8.6.3.3 of these Bylaws, be absolute immunity from civil liability arising from any act, communication, report, recommendation or disclosure performed, given or made, even if the information involved would otherwise be protected. No action, cause of action, damage, liability or expense shall arise or result from or be commenced with respect to any such act, communication, report, recommendation, or disclosure. Such indemnification shall also include an affirmative obligation by Broward Health to fully defend, indemnify and hold harmless such Medical Staff members carrying out in good faith the activities outlined in this Article and in otherwise performing the duties and responsibilities of the Medical Staff as outlined in these Bylaws. Such indemnification shall require Broward Health and the Board to fully indemnify, defend and hold harmless, at Broward Health's expense, the Medical Staff, the Medical Executive Committee, any officer or member of the Medical Staff against whom suit is brought in state or federal court or who is joined in an administrative proceeding before a federal or state agency for an alleged act or omission undertaken by him or her in good faith and within the course and scope of his or her duties as an officer or member of the Medical Staff, including quality assurance, quality improvement or peer review actions or activities, pursuant to these Bylaws or the laws of the United States or the State of Florida and the administrative rules and regulations promulgated thereunder. Notwithstanding the above, the Board shall not be required to defend, indemnify, and hold harmless the officers of the Medical Staff and its Departments, the MEC and such other members of the Medical Staff who are named plaintiffs or relators in an action brought against Broward Health, its employees or agents, any of its affiliates or any of the Medical Staffs. The Board retains the right to select the counsel to represent the Medical Staff member in any action for which the Board indemnifies the member.

Such immunity shall apply to all acts, communications, reports, recommendations and disclosures performed, given or made in connection with, or for, or on behalf of any activities of any other healthcare facility or provider including, without limitation, those relating to:

- 11.4.1. Applications for appointment to the Medical Staff or for clinical privileges;
- 11.4.2. Periodic appraisals or reviews for reappointment or for renewal or revisions to clinical privileges;

- 11.4.3. Corrective action or disciplinary action, including suspension or revocation of Medical Staff membership or clinical privileges;
- 11.4.4. Hearing and appellate review;
- 11.4.5. Medical care evaluations;
- 11.4.6. Peer review evaluations;
- 11.4.7. Utilization review and resource management; and,
- 11.4.8. Any other Hospital, departmental, service, or committee activities related to quality patient care, professional conduct or professional relations. Such matters may concern, involve or relate to, without limitation, such person's professional qualifications, clinical competence, character, fitness to practice, physical and mental condition, ethical or moral standards, or any other matter that may or might have an effect or bearing on patient care.

11.5. RELEASES

In furtherance of and in the interest of providing quality patient care, each applicant for Medical Staff membership or clinical privileges, and each Medical Staff member or individual with clinical privileges shall, by requesting and accepting membership or clinical privileges, release and discharge from loss, liability, cost, damage and expense, including attorney's fees, such persons who may be entitled to the benefit of the privileges and immunities provided in this Article and shall, upon the request of the Hospital or the MEC, execute a written release in accordance with the tenor and import of this Article.

11.6. SEVERABILITY

In the event any provision of these Bylaws are found to be legally invalid or unenforceable for any reason, the remaining provisions of the Bylaws shall remain in full force and effect provided the fundamental rights and obligations remain reasonably unaffected.

11.7. NONEXCLUSIVITY

The privileges and immunities provided in this Article shall not be exclusive of any other rights to which those who may be entitled to the benefit of such privileges and immunities may be entitled under any statute, law, rule, regulation, bylaw, agreement, vote of members or otherwise, and shall inure to the benefit of the heirs and legal representatives of such persons.

ARTICLE XII.
ADOPTION AND AMENDMENT AND GENERAL PROVISIONS

12.1. MEDICAL STAFF AUTHORITY AND RESPONSIBILITY

The Medical Staff shall develop Medical Staff Bylaws to carry out its medical staff functions and such Bylaws, Rules & Regulations, and Medical Staff approved policies so adopted shall comply with local, State and Federal law and regulations, the requirements of the Medicare hospital Conditions of Participation, and applicable mandated accreditation standards.²⁶² Neither the Board nor the Medical Staff may unilaterally amend the Medical Staff Bylaws or Rules and Regulations. The Medical Staff shall comply with and enforce the Medical Staff Bylaws, Rules and Regulations, and Medical Staff approved policies.²⁶³ The Board has authority to approve the Bylaws and such approval shall not be unreasonably withheld. The Board also shall comply with the Bylaws.

12.2. EXCLUSIVE MECHANISM

The mechanism for adoption and amendment described herein shall be the sole method for adoption, amendment or repeal of the Medical Staff Bylaws.

12.3. METHODOLOGY

12.3.1. MEDICAL STAFF BYLAWS

Upon the request of the Unified Medical Staff Committee, the Chief of Staff, the Board of Commissioners, the Bylaws Committee, or upon timely written petition signed by at least ten percent (10%) of the members of the Medical Staff in good standing who are entitled to vote at the initiating hospital, consideration shall be given to the proposed adoption, amendment, or repeal of these Bylaws ("Proposed Bylaw"). Such Proposed Bylaw shall be forwarded to the Bylaws Committee for review and action. If the Proposed Bylaw complies with Section 12.1 above, then the Unified Medical Staff Committee will oversee presenting a ballot on the Proposed Bylaw to be mailed by the medical Staff offices at each Hospital to all members entitled to vote at each such Hospital. The ballot shall specify the timeframe within which the ballots must be returned, that the vote shall be conducted in secret and shall specify that a simple majority of the returned ballots shall determine whether the Proposed Bylaw is approved or rejected. . A representative from Unified Medical Staff Committee for each Hospital shall oversee the opening and tally of the return ballots and shall report the results to the Chair of

²⁶² 42 C.F.R. §482.12(a)(3), Interpretive Guidelines

²⁶³ 42 C.F.R. §482.12(a)(3); 42 C.F.R. §482.22(c); MS.01.01.01

the UMSC. The Chair of UMSC shall then report the results of the ballot to the Board. Bylaws changes adopted by the Medical Staff shall become effective following approval by the Board, which approval shall not be unreasonably withheld. Following material changes to the Bylaws, Rules and Regulations or Medical Staff policies, Medical Staff members shall be provided with a revised text and a current version shall be maintained at the Medical Staff office and available electronically.²⁶⁴

12.3.2. RULES & REGULATIONS AND MEDICAL STAFF POLICIES

As may be required to implement the Medical Staff Bylaws, the Medical Staff shall adopt Rules and Regulations and Medical Staff approved policies which shall outline the administrative process or procedure to implement a specific Bylaw or group of Bylaws but does not replace the Bylaw as the governing document setting forth the organizational structure of the Medical Staff or its primary rules for self-governance, as outlined:

12.3.2.1. Medical Staff Rules and Regulations and Medical Staff approved Policies: Subject to approval by the Board, which approval shall not be withheld absent a good cause determination such rules and regulations or Medical Staff approved policies are contrary to the Bylaws or otherwise arbitrary or illegal or contrary to the best interests of Broward Health or the operations or delivery of patient care at the applicable Hospital, the Unified Medical Staff Committee, acting on behalf of all of the Medical Staffs for each Hospital, shall adopt such Rules and Regulations and Medical Staff approved policies as may be necessary to implement these Bylaws. The Medical Council for each Hospital may also adopt additional Rules and Regulations applicable only to their respective Hospitals as may be required based upon the resources available or particular operations of that Hospital, such additional Rules and Regulations shall be approved by the Governing Board, which approval shall not be unreasonably withheld.

12.3.2.2. Department Rules and Regulations and Policies: Subject to the approval of the Medical Executive Committee, acting on behalf of the Medical Staff, and the Board, each Department shall formulate its own Department Rules and Regulations and policies for the conduct of its affairs and the discharge of its responsibilities. Such Department Rules and Regulations and policies shall not be inconsistent with these Bylaws and the Rules and Regulations or Medical Staff approved policies.

²⁶⁴ MS.01.01.01; MS.02.01.01; LD.02.01.01; LD.03.04.01

12.4. TECHNICAL AND EDITORIAL AMENDMENTS

The Unified Medical Staff Committee may correct typographical, spelling, grammatical or other obvious technical or editorial errors in the Bylaws and Rules and Regulations.

12.5. GENERAL PROVISIONS

12.5.1. SUCCESSOR IN INTEREST

These Bylaws and the membership accorded under these Bylaws will be binding upon the Medical Staff and the Board of any successor in interest to said entities. In the event that the Medical Staffs of any one or more of the Hospitals of Broward Health become combined, the applicable Medical Staffs shall work together to develop new bylaws which will govern the combined medical staffs, subject to the approval of the voting members of the affected Hospitals and the Board. Until such time as the new bylaws are approved, the existing Bylaws of this Medical Staff shall remain in effect.

12.5.2. AFFILIATIONS

Affiliations between the Hospital and other hospitals, healthcare systems, or other entities shall not, in and of themselves, affect these Bylaws.

12.5.3. NO IMPLIED RIGHTS

Nothing contained herein is intended to confer any rights or benefits upon any individual or to confer any private right, remedy, or right of action upon any person, except as expressly set forth herein. These Bylaws and the Rules and Regulations are intended for internal Hospital use only and solely for the self-governance of the Medical Staff in the performance of its stated functions and its rights and relations with the Governing Body and its Members. No third party is authorized to rely on any provisions of these Bylaws or the Rules and Regulations except as specifically provided herein, and no third party may personally enforce any provision hereof, except as specifically provided.

12.5.4. NOTICES

Any notices, demands, requests, reports or other communications required or permitted to be given hereunder shall be deemed to have been duly given if in writing and delivered personally or deposited in the United States first class mail, postpaid, to the person entitled to receive

notice at his/her last known address, except as otherwise provided in these Bylaws or in the Rules and Regulations.

12.5.5. LEGAL COUNSEL

Recognizing the Medical Staff's legally mandated role as an important and active element of Broward health and of each Hospital of Broward health, especially in quality assessment/performance improvement and peer review matters, the Medical Council of all Hospitals shall have available to them for assistance and advise one independent legal counsel who shall be selected by UMSC and serve at the pleasure of the majority of the Chiefs of Staff at the Hospitals for all the Hospitals individually and collectively with respect to all Medical Staff business. The expense for such counsel shall be borne by Broward Health provided such counsel shall charge reasonable fees for services rendered in accordance with the standards for same in the community as determined by the Legal Review Committee of the Board. However, nothing contained herein shall be construed to obligate Broward Health or the Board for the payment of attorney's fees or costs associated with actions or litigation adversarial to the District or the Board brought by the Medical Staff, Medical Council(s) or any member of the Medical Staff, or actions brought by the Medical Council(s), Medical Staff, or any member of the Medical Staff against any third party, unless ordered by the Court in which such action was maintained.

12.5.6. CONFLICT OF INTEREST

Individuals shall disclose any conflict of interest, as per Section 7.6.5, or potential conflict of interest in any transaction, occurrence or circumstance which exists or may arise with respect to his/her participation on any committee or in his/her activities in Medical Staff affairs, including in departmental activities and in the review of cases. Where such a conflict of interest exists or may arise, the individual shall not participate in the activity, or as appropriate, shall abstain from voting, unless the circumstances clearly warrant otherwise. This provision does not prohibit any person from voting for himself/herself nor from acting in matters where all others who may be significantly affected by the particular conflict of interest consent to such action.

12.5.7. NO AGENCY

Physicians, other practitioners, and other individuals with clinical privileges shall not, by virtue of these Bylaws or Medical Staff appointment, be authorized to act on behalf of, or bind the Hospital, and shall not hold themselves out as agents, apparent agents or ostensible agents of the Hospital, except where specifically and expressly authorized in a separate written contract with the Hospital.

12.5.8. CONFLICT

In the event that these Bylaws, including provisions for Fair Hearing, shall conflict with the Rules and Regulations or the policies of the Medical Staff, the provisions of these Bylaws shall control.

12.5.9. ENTIRE BYLAWS

These Bylaws are the entire Medical Staff Bylaws of the Hospital and supersede any and all prior Medical Staff Bylaws that, by adoption hereof, shall be automatically repealed.

ARTICLE XIII. CERTIFICATION OF ADOPTION AND APPROVAL

These Bylaws shall be adopted by mailed ballot of the Active Medical Staffs of Broward Health Hospitals and shall replace any previous Bylaws and shall become effective when approved by the Board of Commissioners. They shall, when adopted and approved, be equally binding on the Board of Commissioners and the Medical Staffs.

Date

Chairperson
Unified Medical Staff Council

Approved by the Board of Commissioners of Board Health.

Date

President/Chief Executive Officer
Broward Health

Date

Chairperson
Board of Commissioners